From the Nurse

GILLINGHAM CHARTER SCHOOL

Medical Emergency Form

Please complete and return to school office:

Student Name: _____ Grade: _____

Address: _____

Mother/Guardian: _____

Home #: _____ Cell #: _____ Work #: _____

Father/Guardian: _____

Home #:_____ Cell #: _____ Work #:_____

If Parents/Guardians cannot be reached:
(Please make sure these people are notified that they will be contacted as emergency backup and are available to pick up your student(s) from school and take your student(s) home.
Other persons to contact- PLEASE NAME THREE-MUST BE AUTHORIZED STUDENT PICK UP

1._____ Relationship _____ Phone No._____

2. _____ Relationship _____ Phone No. _____

3._____ Relationship _____ Phone No. _____

Primary Doctor: _____ Phone No. _____

Hospital preference _____ Insurance Info: _____

Please list any/all information that will help our staff provide care for your child:

Allergies: _____

Chronic Medical Conditions: _____

Consent to Treat
I hereby give my permission to Gillingham Charter School and its school nurse/designated employees to administer and coordinate emergency treatment if an accident or serious illness occurs at school and I cannot be reached. I understand this may include basic first aid and CPR, and transportation to an emergency facility per ambulance.

I hereby accept financial responsibility for transportation and treatment in the event such action is necessary. I acknowledge that this information will be shared with appropriate school staff when necessary to protect the health or safety of my student(s) or other persons.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name Printed: _____

SCHOOL VACCINATION REQUIREMENTS
FOR ATTENDANCE IN PENNSYLVANIA SCHOOLS

FOR ATTENDANCE IN ALL GRADES CHILDREN NEED THE FOLLOWING:

- 4 doses of tetanus, diphtheria, and acellular pertussis* (1 dose on or after the 4th birthday)
- 4 doses of polio (4th dose on or after 4th birthday and at least 6 months after previous dose given)**
- 2 doses of measles, mumps, rubella***
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox) or evidence of immunity

**Usually given as DTP or DTaP or if medically advisable, DT or Td*
*** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose*
****Usually given as MMR*

ON THE FIRST DAY OF SCHOOL, unless the child has a medical or religious/philosophical exemption, a child must have had at least one dose of the above vaccinations or risk exclusion.

- If a child does not have all the doses listed above, needs additional doses, and the next dose is medically appropriate, the child must receive that dose within the first five days of school or risk exclusion. If the next dose is not the final dose of the series, the child must also provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.
- If a child does not have all the doses listed above, needs additional doses, and the next dose is not medically appropriate, the child must provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.
- The medical plan must be followed or risk exclusion.

FOR ATTENDANCE IN 7TH GRADE:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) on the first day of 7th grade.
- 1 dose of meningococcal conjugate vaccine (MCV) on the first day of 7th grade.

ON THE FIRST DAY OF 7TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

FOR ATTENDANCE IN 12TH GRADE:

- 1 dose of MCV on the first day of 12th grade. If one dose was given at 16 years of age or older, that shall count as the twelfth grade dose.

ON THE FIRST DAY OF 12TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

The vaccines required for entrance, 7th grade and 12th grade continue to be required in each succeeding school year.

These requirements allow for the following exemptions: medical reason, religious belief, or philosophical/strong moral or ethical conviction. Even if your child is exempt from immunizations, he or she may be excluded from school during an outbreak of vaccine preventable disease.

Pennsylvania's school immunization requirements can be found in 28 Pa.CODE CH.23 (School Immunization). Contact your healthcare provider or call 1-877-PA-HEALTH for more information.

pennsylvania
DEPARTMENT OF HEALTH

GILLINGHAM
CHARTER SCHOOL
A Charlotte Mason Public Education

MEDICATION CONSENT FORM

Student Name ____ **Grade** ______ **School Year** ________________

In order to help protect your child's health, your consent and written authorization from a health care provider with prescriptive authority is required when it is necessary for your child to receive prescription and/or non-prescription medicines.

Parent/Guardian Permission: I give permission for my child to receive this medicine during school hours. Arrangements for administration of medication essential to your child's health while on field study is the parent's responsibility, please notify the nurse anytime your child attends a field study. I also give permission for school nurse to contact the prescribing healthcare provider with questions/concerns. I understand that it is my responsibility to purchase and supply this medicine in its original container. On behalf of my child I absolve the Gillingham Charter School and employees from any and all liability whatsoever that may result from my child taking this medicine.

______________________________ ______________________________ ______________
Parent/Guardian Printed Name Parent/Guardian Signature Date

- -

Medical Diagnosis: ____

1. Medication/ Strength
   ______________________________Directions______________________________________
2. Medication/ Strength
   ______________________________Directions______________________________________
3. Medication/ Strength
   ______________________________Directions______________________________________

☐ Check if any above medication is to be used for emergencies/self-carry.

*******Both sides of this form are required for emergency self-carry medications*******

Specific Directions (include at what time, relationship to meals, specific indications if "as needed"):

____
____
____

Expected side effects or adverse reactions:____

Specific indication____

Other information: ____

Healthcare Provider Permission: It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the school nurse or principal if there are any problems or change to medication order.

______________________________ ______________________________ ______________
Signature of Healthcare Provider Print practitioner's last name Date

______________________________ ______________________________ ______________
Practice name Practice Address Practice Phone

GILLINGHAM
CHARTER SCHOOL
A Charlotte Mason Public Education

AUTHORIZATION FOR SELF-CARRY EMERGENCY MEDICATIONS

*Eligibility: Students with asthma, diabetes and/or severe allergies who may require rescue medications

Student Name _____ **Grade** _____ **Birth Date** _____

I agree that the above named student is responsible and capable of self-administration of the following medications. (Please check all that apply) :

- ☐ Rapid-Acting bronchial inhaler (please include medication name, dose and frequency)
  _____
- ☐ Auto- Injectable Epinephrine (please include medication name, dose and frequency)
  _____
- ☐ Gulcagon Injection (please include medication name, dose and frequency)
  _____

- -

Healthcare Provider Permission: This student is capable of and has been instructed on how to self-carry and, if applicable, administer this medication as directed on the medication consent form (both correct technique and dose intervals). Please allow him/her to self-carry it during school hours or activities.

_____ _____ _____
Signature of Healthcare Provider | Print practitioner's last name | Date

Parent/Guardian Permission: I give consent to the Gillingham Charter School to allow my child to self-carry and, when applicable, to self-administer this medicine at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. I will provide backup medication to be kept at school. I absolve the Gillingham Charter School and their agents and employees from any and all liability whatsoever that may result from my child carrying this medicine at school.

_____ _____ _____
Parent/Guardian Printed Name | Parent/Guardian Signature | Date

Student: I am capable of carrying this medicine as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to disciplinary actions if medications are shared. I will inform an adult when medication is used.

_____ _____ _____
Student Printed Name | Student Signature | Date

H514.027 (08/2011-under review)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20 ___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
_____ Last First Middle		☐ M ☐ F		

ADDRESS

_____
No. and Street City or Post Office Borough/Township County State Zip

REPORT OF EXAMINATION

TOOTH CHART

	RIGHT								**LEFT**								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address

pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date_____

Date of birth _____ Age at time of exam_____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: ***Has the student…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: ***Has the student…***	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: ***Has the student...***	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **DURING** or **AFTER** exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: ***Has the student...***	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: ***Has the student…***	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: ***Has the student…***	**YES**	**NO**
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student…***	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student_____ Date_____

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	**CHECK ONE**			***ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS**
	NORMAL	***ABNORMAL**	**DEFER**	
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	**DATE APPLIED**	**DATE READ**	**RESULT/FOLLOW-UP**

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____

Print name of examiner _____

Print examiner's office address_____ Phone_____

Signature of examiner_____ MD ☐ DO ☐ PAC ☐ CRNP ☐

STUDENT NAME:

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)
STUDENT NAME:

Date of Issue September 2017

Provision of School Health Services and Mandated School Health Services

School entities are to provide the following health services for students who attend or who should attend an elementary, grade or high school, either public or private, and children who are attending a kindergarten which is an integral part of a local school district. These requirements also apply to students who are home schooled.

Mandated School Health Services

SERVICE	K	1	2	3	4	5	6	7	8	9	10	11	12	Notes
School Nurse Services	X	X	X	X	X	X	X	X	X	X	X	X	X	
Maintenance of Health Record	X	X	X	X	X	X	X	X	X	X	X	X	X	
Immunization Assessment	X	X	X	X	X	X	X	X	X	X	X	X	X	
Medical Examination	*	*					X					X		*Required on original entry- K or 1st grade
Dental Examination	*	*		X				X						*Required on original entry- K or 1st grade
Growth Screen	X	X	X	X	X	X	X	X	X	X	X	X	X	
Hearing Screen	X	X	X	X				X				X		
Scoliosis Screen							X	X						6th grade physical may be used in lieu of 6th grade screen
Tuberculin Test	*	*								X				*Required on original entry- K or 1st grade. Unless approved to discontinue
Vision Screen-Far Visual Acuity Test	X	X	X	X	X	X	X	X	X	X	X	X	X	
Vision Screen-Near Visual Acuity Test	X	X	X	X	X	X	X	X	X	X	X	X	X	
Vision Screen-Convex Lens Test (Plus Lens)		X												1st grade students meeting criteria & new students (any grade) not previously screened
Vision Screen-Color Vision Test		*	*											*1st or 2nd grade & new students (any grade) not previously screened
Vision Screen-Stereo/Depth Perception Test		*	*											*1st or 2nd grade & new students (any grade) not previously screened