Greensburg Salem School District

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Superintendent

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We are advised that your child will be entering our school in the fall. It is the aim of the school system to provide every child with broad and sound educational opportunities. The Health Department is staffed by registered nurses as well as elected doctors and dentists. One service is to conduct vision and hearing tests in accordance with State regulations. If your child has a special health problem, please call this to our attention. It is important to guard the health of every child in the Greensburg Salem School District.

We recommend that you make arrangements immediately for a medical checkup, including immunizations, for your child. When school opens, local physicians will need to examine many school children, so it is important that you make your appointment as soon as possible.

Remember that you are also requested to bring the child's birth certificate on orientation day so that his/her legal name may be checked. If your child does not have a birth certificate, please obtain one from the Pennsylvania Department of Health, Division of Vital Statistics, Room 401 Central Building, 101 South Mercer Street, New Castle, PA 16101. There is a $10.00 fee for this certificate. Please enclose a stamped, self-addressed envelope, or go to their website at **www.health.state.pa.us/vitalrecords** for more information and on-line ordering.

Your attention is called to the following Pennsylvania Mandates:

1. Records and Immunizations

State Law requires each school to maintain permanent health and dental records for each child enrolled. So that we obtain the information required, please fill out and return the enclosed Health History form (pink) on orientation day. **Your school nurse will also need a copy of the immunization record that has been medically documented by the physician or clinic that has administered these immunizations.**

Every Pennsylvania school district, both public and private is required by State Law to refuse admission to any child who has not been completely immunized receiving diphtheria, tetanus, polio, measles and mumps vaccines, hepatitis B series and either chicken pox vaccine (varivax) or documentation of month and year of chicken pox disease.

(over please)

Verification by month, day and year as to when the immunizations were received must be provided for the following:

Diphtheria (*4 doses) **Fourth Dose of Diphtheria must be given after age 4.*	
Tetanus (*4 doses) **Fourth Dose of Tetanus must be given after age 4.*	
Polio (3 doses, oral)	
Measles	
Mumps	**Must be given after 1 year of age.* **MMR or Measles Booster #2 Before Entrance to School*
German Measles (Rubella)	
Hepatitis B Vaccine (series of 3 injections)	
Varicella (Chicken Pox) (*2 doses) **Immunization, or parent documentation of Chicken Pox Disease, including month and year of disease.*	

For the safety of all children, the state requires that all students entering school must have proper documented immunizations. <u>An official copy of immunizations (record signed by the physician's office) must be brought to school for orientation</u>.

2. <u>Physical Examination</u>
We encourage you to have your child under the regular care of the physician of your choice. Please return the enclosed report of your child's most recent examination. **<u>Only physicals completed and dated after September 1, 2011 are acceptable</u>.** If you are unable to provide an examination at this time, your child will be examined by a school physician.

3. <u>Dental Examination</u>
Every child should visit his dentist once or twice a year. The school will request reports of these visits in grades one, three and seven. If these reports are not returned in the fall of the current year, the dental examination will be given in school.

AN:dec

H511.336 (Rev. 5/02)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

DATE ________________ 20 ______

NAME OF SCHOOL ______________________________ GRADE _____ HOMEROOM ________

NAME OF CHILD Last First Middle	DATE OF BIRTH	SEX ☐ M ☐ F

ADDRESS

No. and Street | City or Post Office | Borough or Township | County | State | Zip Code

MEDICAL HISTORY

IMMUNIZATIONS AND TESTS

VACCINE	DOSES (Enter Month, Day, And Year Each Immunization Was Given)			BOOSTERS & DATES	
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, Td	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	Varicella Disease or Lab Evidence Date:________		
Other ________					

☐ MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health

☐ RELIGIOUS EXEMPTION (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

If Applicable:

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	**Results (mm)**		**Signature**		

Follow-Up of significant tuberculin tests:

Parent/Guardian notified of significant findings on. ________ Date

Result of Diagnostic Studies: ______________________ . Date

Preventive Anti-Tuberculosis - Chemotherapy ordered. ☐ No ☐ Yes ________ Date

(Continued on Back)

Significant Medical Conditions (✓)

	Yes	No	If Yes, Explain
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify ______________________________

Report of Physical Examination (✓)

	Normal	Abnormal	Not Examined	Comments
Height (inches)				
Weight (pounds) BMI				
Pulse ( )				
Blood Pressure /				
Hair/Scalp				
Skin				
Eyes/Vision				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart — Murmur, etc.				
Lung — Adventitious Findings				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Presence of Scoliosis)				

____
Date of Examination

______________________________ ______________________________
Signature of Examiner **Print** Name of Examiner

______________________________ ______________________________
Address Telephone Number