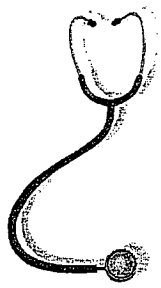

Medical History

Child's Full Name _____
(Last) (First) (Middle)

Date of Birth: _____ S.S. #: _____

Mother's Maiden Name _____

Mother's Name _____

Father's Name _____

Address: _____ Telephone: _____

_____

Child's Physician: _____ Telephone: _____

Other Pertinent Information: (Special Health Problems, Home and Family Conditions, Family Medical History, and Parent Concerns)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____
Parent/Guardian Signature Date Form Completed

Leechburg Area School District

ADMINISTERING MEDICINES TO STUDENTS

LEECHBURG AREA SCHOOL DISTRICT

Medicine Permission Form

Please complete the following information and enclose with each medicine you send with your child to be taken during school hours. Do not omit any information. This form must be signed by a licensed physician for prescription drugs. The over-the-counter medications only need parent's signature and/or physician's signature of approval.

STUDENT'S NAME _____ GRADE _____ HOME ROOM TEACHER _____

DIAGNOSIS _____

MEDICATION / DOSAGE / TIME _____

(CIRCLE ONE) PRESCRIPTION NON-PRESCRIPTION

LENGTH OF TIME MEDICATION IS TO BE GIVEN _____

POSSIBLE SIDE EFFECTS OF MEDICATION _____

PHYSICIAN'S SIGNATURE _____ DATE _____

I, the parent/guardian, authorize the school nurse to administer the above medication as prescribed or supervise self-administering of over-the-counter medication. I will take full responsibility for the prescribed medication which is to be taken during school hours. I also understand in an emergency condition and the school nurse is not immediately available, the attending teacher when trained by the school nurse may administer the emergency medication following the written instructions from the physician.

PARENT'S SIGNATURE _____ DATE _____

ALL PRESCRIPTION MEDICINE MUST BE IN THE APPROPRIATE PHARMACY CONTAINER LABELED WITH THE NAME OF THE STUDENT, THE AMOUNT TO BE TAKEN AND THE TIME TO BE TAKEN.

ALL OVER-THE-COUNTER MEDICINE MUST BE IN THE MANUFACTURER'S ORIGINAL CONTAINER AND LABELED BY THE PARENT WITH THE CHILD'S NAME, DOSAGE TO BE TAKEN AND THE TIME TO BE TAKEN.

THIS FORM IS TO BE PRESENTED TO THE SCHOOL NURSE AND THE FORM IS TO BE RETAINED IN THE NURSE'S OFFICE.

ONLY MEDICATION THAT IS BROUGHT IN BY THE PARENT/GUARDIAN WILL BE GIVEN IN SCHOOL.

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 19____

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

ADDRESS

No. and Street | City or Post Office | Borough or 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

H511.336 (Rev. 6/97)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

DATE _____ 19 _____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD	AGE	SEX
Last First Middle		☐ M ☐ F

ADDRESS

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

MEDICAL HISTORY

IMMUNIZATIONS AND TESTS

VACCINE	Enter Month, Day, And Year Each Immunization Was Given DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus*	1 / /	2 / /	3 / /	4 / /	5 / /
Polio	1 / /	2 / /	3 / /	4 / /	5 / /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Other _____					

* *Tetanus and Diphtheria are usually received in combined vaccines such as DTP, DT, or Td*

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

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

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

ollow-Up of significant tuberculin tests:

arent/Guardian notified of significant findings on _____.
Date

esult of Diagnostic Studies: _____.
Date

eventive 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)	☐	☐	

Report of Physical Examination (✓)

	Normal	Abnormal	If Abnormal, Explain
• Height (inches)			
• Weight (pounds)			
• Pulse ( )			
• Blood Pressure /			
• Hair/Scalp			
• Skin			
• Eyes — Visual Acuity R__/__ L__/__			
• Eyes — Color Vision			
• Ears — Hearing dB R L			
• Nose and Throat			
• Teeth and Gingiva			
• Lymph Glands			
• Heart — Murmur, etc.			
• Lung — Adventious Findings			
• Abdomen			
• Genitalia			
• Neuromuscular System			
• Extremities			
• Spine (Presence of Scoliosis)			

Date of Examination

Signature of Examiner

Print Name of Examiner

Address