To: Parents / Guardians of Incoming 9th Graders
From: Central Catholic High School Nurses
RE: Mandatory Medical Forms for Admission

Attached are important medical forms that must be completed as part of the admission process.

-Health Survey

-Immunizations

Please send a copy of your son's immunizations, 2 doses of Varicella, 1 dose of Tdap, and 1 dose of meningitis is required for grades 7 – 12. This is a state requirement. Students who do not provide immunization records may not be permitted to attend school.

-Physician's Report of Physical Examination

The School Health Program requires medical examinations for students in Grades K, 6, and 9. These grades were selected because they represent critical periods of growth and development in a child's life. We are recommending that the examination be done by your family physician since he/she can best evaluate your child's health and assist you in obtaining necessary treatment and corrections.

-Medical Consent Form

Over-the-counter (OTC) medicine: in order for the school nurse to distribute OTC medication, a parent must sign the enclosed medical consent form

Prescription Medicine: authorization from both parents and physician is required when prescription medication is required during school hours. This must also be in the bottle in which it was received with the instructions/ dosages included.

Please have the attached forms completed by your family physician and return it to the school nurse at the start of the school year.

Thank you for your cooperation in this important matter.

MEDICAL CONSENT FORM

The Pennsylvania Department of Health has issued new guidelines concerning the dispensing of medication in school. In order to dispense any prescription or non-prescription drugs, Central Catholic High School must have a permission form signed by a parent on file in the Nurse's Office.

Please check the appropriate lines below, sign and return to Central Catholic High School. Legally, the school cannot dispense medication without this signed form. Please return this signed form to the school nurse.

STUDENT'S NAME: _____

Please indicate by way of a checkmark those OVER-THE-COUNTER medications that may be dispensed to your son:

_____Acetaminophen (Tylenol) for a headache
_____Ibuprofen (Advil)
_____Antacid tablet for an upset stomach
_____Benadryl for allergies

PARENT OR GUARDIAN'S SIGNATURE:_____

The following PRESCRIPTION MEDICATION (must have a *physician* & *parent* signature)

Name of medication:_____ Dosage:_____
Time to be administered:_____

Length of Time given:_____Route:_____Schedule:_____

Possible side effects:_____

_____	_____	_____
Date	Telephone	Physician's Signature
_____	_____	_____
Date	Telephone	Parent's Signature

EMERGENCY CONTACT FORM

Name:_____ Date of Birth: _____
Name(s) of Parent(s):_____
Street Address/Zipcode: _____
Home Phone Number: _____
Phone numbers where parent(s)/caregivers may be reached during the daytime (Including area code):

_____

In case of illness or injury, when neither parent(s)/caregiver can be reached, who should be contacted?
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Does your child have any allergies? YES NO
If yes, please list: _____
Are the allergies life-threatening, requiring an EpiPen at school? YES NO

Does your child have any health concerns the school should be aware of? YES NO
If yes, please list (ie asthma): _____
Is your child on any medications? YES NO
If yes, please list: _____

Does your child need to take the medicine at school? YES NO
If so, you will need to complete our medication form.

During the past year, has your child had any serious illness, injury, operation, or hospitalization?
YES NO
If yes please list: _____

Has your child received any immunizations with the past year? YES NO
If yes, please list: _____

Please list your doctor or source of health care: _____

_____

Date: _____ Parent Signature: _____

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	DATE OF BIRTH	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 (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

Results 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 effect 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 & 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