H514.027

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 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

THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REQUEST FOR ADMINISTRATION OF MEDICATION, TREATMENTS OR USE OF EQUIPMENT IN SCHOOL

(PLEASE SEE MESSAGE TO PHYSICIAN AND PARENT ON BACK OF FORM)

PHYSICIAN, PLEASE NOTE: Fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication / treatment. A separate request is needed for each medication.

NAME OF PATIENT/STUDENT	ADDRESS/ZIP	ROOM/BOOK NO.

DATE OF BIRTH	SCHOOL/ORG.#	REGIONAL OFFICE	PID

DIAGNOSIS:

REASON MEDICATION MUST BE GIVEN IN SCHOOL:

NAME OF MEDICATION/EQUIPMENT/TREATMENT:	DOSE:

TIME(S) TO BE GIVEN IN SCHOOL:	TOTAL DOSAGE PER 24 HRS:

DATE BEGIN:	DATE END:

INSTRUCTION FOR ADMINISTRATION/UTILIZATION:

CONTRAINDICATIONS:

SIDE EFFECTS: _____

TREATMENT OF SIDE EFFECTS/ACTION TO BE TAKEN: _____

IS ANY RESTRICTION ON ACTIVITY NECESSARY: YES ☐ NO ☐

IF YES, DESCRIBE: _____

IS STUDENT TAKING ANY OTHER MEDICATION? YES ☐ NO ☐

IF YES, NAME OF MEDICATIONS: _____

IS SIMILAR EQUIPMENT KEPT BY THE CHILD'S FAMILY AT HOME? YES ☐ NO ☐

PRINT NAME OF HEALTH CARE PROVIDER/CREDENTIALS	TELEPHONE
ADDRESS	EMERGENCY NUMBER
SIGNATURE OF HEALTH CARE PROVIDER	DATE SIGNED

To The Principal

- I authorize selected school personnel to administer the indicated medication, or to use the equipment or machinery as prescribed by my child's health care provider, whose signature appears on this form.
- Medication is to be administered by the Certified School Nurse. In the absence of the Certified School Nurse, it may be administered by the Principal or his/her designees.
  Certified School Nurse will provide instruction for administration of medication or use of equipment to the Principal or his/her designees.
- My child may self-administer medication/equipment as determined appropriate by the school nurse.
- I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply, as needed, regarding this medication/ equipment and/or my child's response.

PARENT SIGNATURE _____ TELEPHONE NUMBER _____

DATE SIGNED _____ EMERGENCY NUMBER _____

IN ACCORDANCE WITH CURRENT SCHOOL DISTRICT PROCEDURE

- I have assessed this student and he/she has demonstrated competency and may self administer this medication/treatment (__) yes (__) no
- The administration of this medication/treatment was approved on: _____ DATE

SIGNATURE OF SCHOOL NURSE _____

TELEPHONE NUMBER OF SCHOOL NURSE _____

DISTRIBUTION OF COPIES: SCHOOL NURSE- KEEPS ORIGINIAL; PARENT- KEEP COPY

TO THE PHYSICIAN:
Your patient has requested that medication or equipment be utilized in school. Ideally, the administration of medication or utilization of equipment should take place at home. However, for students who require medication/treatment during the school day in order to function in the classroom, School District Policy does permit selected school staff to administer medication. In some cases, students may self-administer their medication.

School District Policy also permits the use of equipment/machinery in those instances where similar equipment is kept by the child's family at home, and such equipment/machinery is necessary in order to enable the student to function in the classroom. Instruction for use and precautions should be spelled out in detail.

(IF YOUR PATIENT'S MEDICATION OR TREATMENT SCHEDULE CANNOT BE ALTERED SO THAT ALL ARE RECEIVED AT HOME, PLEASE COMPLETE THE REQUEST ON THE REVERSE SIDE - A SEPARATE REQUEST IS REQUIRED FOR EACH MEDICATION OR TREATMENT).

When the medication/treatment prescribed exceeds or differs from that approved by the FDA or recommended by the manufacturer, you and the child's parent will be required to submit written detailed information to the School Nurse. This must include a list of side effects and confirmation that all side-effects have been explained to and are understood by the parent. Any particularly dangerous conditions being experienced by the child should be spelled out in detail, with the procedure to follow should a reaction occur.

Please fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication/treatment.

Thank you

School Health Services

DEAR PARENT/GUARDIAN:

Some children need the administration of medication or special equipment in order to function in the classroom. Ideally, this should take place at home. If your child's medication/equipment schedule cannot be altered so that everything can be administered at home, you can request that they be given in school by seeing the school nurse or principal. When the medication/treatment prescribed for your child exceeds or differs from that approved by the FDA or the manufacturer, you and your health care provider will be required to submit additional written information to the School Nurse prior to approval.
Once the request has been approved by the School Nurse, you will be required to bring the medication to school properly labeled and packaged by a Registered Pharmacist. The medication bottle must have Saf-T-Closure Cap and the label must include:

- Patient Name
- Pharmacy Name
- Pharmacy Address and Phone#
- Prescription Number
- Prescription Date (current)
- Name of medication, dosage form, expiration date (if relevant)
- Instructions for administration
- Name of prescribing health care provider

For special equipment, services in school will be provided only if you have such equipment in your home. You must provide the equipment as well as repair and replace it when necessary. After the request is approved, you will be asked to bring the equipment to school and to demonstrate its use to selected school staff. Operating instructions must accompany the equipment.
This procedure must be repeated each school year and/or each time there is a change in dosage.
Parents/guardians must pick up unused or expired medication in person, or send an authorized responsible adult with a note from you. Unused medication which is not picked up within 10 days, or by the last day of school will be destroyed/discarded.
If you have any questions on this procedure, please contact the school nurse or school principal.

Thank you

H511.336

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

AGE

SEX ❑ 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 / /	1 / /	1 / /		
HIB	1 / /	1 / /	1 / /		
Other: Varicella_____					

** 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 Dates 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

Preventative 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