Please email completed paperwork to: palumboadmissions@gmail.com

THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

Date Issued: [Date]		Student ID#:
Name of Student:	Date of Birth:	Grade:
Name of School:	Room/Section/Book	

TO THE PARENT/GUARDIAN:

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian Signature____Date_______________________________

TO THE CARE PROVIDER (Please complete all items)

Pennsylvania law requires that students attending school in the state be immunized and receive periodic medical examinations. Payment for these examinations is the responsibility of the parent/guardian. THESE IMMUNIZATIONS ARE REQUIRED FOR SCHOOL ATTENDANCE.

RECORD OF VACCINE ADMINISTRATION

(Please attach complete immunization record including serology results if available)

- Allergies___________________________
- Date of last PPD______________________Result__________________mm

Does this student have health insurance? _____ Yes ______ No   Name of Insurance Provider:____

RECORD THE FOLLOWING

1. Visual Acuity: Without Glasses: R_________ L _________ With Glasses: R __________ L __________
2. Audiometric Screening: R ___________ L ____________ 3. BP _____________________
4. Height _______________ inches/cm Weight __________________lb./kg BMI percentile ____________________
5. Scoliosis Screening: __________ Normal __________Abnormal __________ Referred __________ No Referral
6. Activity Recommendation: __________ Full Physical Activity ______________Restricted Physical Activity
   (Must Complete Phys. E. Medical Exemption/Program Modification Form MEH-23)
   Specify Restrictions:____
7. List all medications currently being taken:
   Medications:____Reason:____
8. List ALL problems by history or examination: Circle status of problem
   1.____ Under Care Care Complete Referred
   2.____ Under Care Care Complete Referred
   3.____ Under Care Care Complete Referred
   ______ No Problems Identified

Comments/follow-up treatment plan / Special instructions to school:

Signature of Care Provider (REQUIRED)	Telephone Fax	Care Provider office stamp (REQUIRED)
Address	Date of Exam	

*Complete for inhaler use only

THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REQUEST FOR ADMINISTRATION OF ASTHMA MEDICATION

(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	PID

DIAGNOSIS:

REASON MEDICATION MUST BE GIVEN IN SCHOOL:

NAME OF MEDJCATION:	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: ____________________

RESTRICTION ON ACTIVITY: YES ☐ NO ☐

IF YES, DESCRIBE: ____________________

IS STUDENT TAKING ANY OTHER MEDICATION? YES ☐ NO ☐

IF YES, NAME OF MEDICATIONS: ____________________

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

I authorize licensed school personnel to administer the indicated medication as prescribed by my child's health care provider, whose signature appears on this form

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 and/or my child's response.

PARENT SIGNATURE ____________________ TELEPHONE NUMBER ____________________

DATE SIGNED ____________________ EMERGENCY NUMBER ____________________

In accordance with school district procedure:

- I have assessed the student and s/he has demonstrated competency to self-administer medications.
  YES____NO______
- The administration of this medication was approved on:
  ____

SIGNATURE OF SCHOOLNURSE ____________________

TELEPHONE NUMBER OF SCHOOL NURSE ____________________

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. **Steps to take during an asthma episode:**

- Remove student from any obvious trigger listed above
- **DO NOT** leave student alone.
- Sit student comfortably leaning forward, **DO NOT** insist that they lie down.
- Check student's peak flow reading (if available)
- Give initial treatment of emergency school asthma medication and allow for rest. Improvement from bronchodilators is usually seen within 5-10 minutes after use of inhaler.
- Check for decreased symptoms (or increased peak flow reading)
- Contact parent/guardian to make them aware of asthma episode and effectiveness of treatment.
- If symptoms **DO NOT** decrease after initial treatment with medication, the situation can quickly become an asthma emergency. **CALL 9-1-1 if condition worsens.**

TO THE PHYSICIAN:

Your patient has requested that medication be administered in school. Ideally, the administration of medication should take place at home. However, for students who require medication during the school day in order to function in the classroom, School District Policy does permit licensed school staff to administer medication. In some cases, students may self-administer their medication.

IF YOUR PATIENT'S MEDICATION 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.

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 in order to function in the classroom. Ideally, this should take place at home. If your child's medication schedule cannot be altered and administered at home, you can request the medication to be given in school by seeing the school nurse.

Once the School Nurse has approved the request, 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

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.

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