Dear Parents and Guardians,

This packet contains very important information regarding your student. Attached are the following forms:

**Immunization Compliance Requirements** - Please take note that 12th graders require a second dose of meningococcal conjugate vaccine (MCV) due before entering 12th grade.

**Special Health Needs** - To be completed by parent.

**Report of Physical Exam** - To be completed by Primary doctor or Nurse Practitioner upon entry and 11th as required by the State of Pennsylvania.

**Report of Private Dental Exam** - To be completed by Dentist upon entry and 11th grade as required by the State of Pennsylvania.

**Student Emergency/Medical Information** - To be completed by parent. Please take note of the box containing permission to give medication (Acetaminophen or Ibuprofen) while students are in school. Please circle Yes or No for each medication so we can administer medication if you would like them to receive it in school after we do a short assessment.

Each of these forms are very important. We ask that you have all of the forms completed before handing it into school for your child to be registered. This will allow us to take good care of your students while they are in school with us.

Thank you for allowing us to take care of your student!

The Nursing Department

215-400-3201 (Option 3)
New requirements for Philadelphia students:

Upon admission and all 11th grade students are required to have a physical on file. Sports physicals are acceptable. A dental exam is required upon admission. Required forms are attached, sports forms are available from the coach.

Required immunizations effective 2017/2018 school year:
4 doses of tetanus, diphtheria, and acellular pertussis, one must be after 4th birthday
   Another dose is to be given at entry into 7th grade
4 doses of polio, one after 4th birthday and 6 mos. after the previous dose
2 doses of measles, mumps, rubella (MMR), both after 1st birthday
2 doses of chicken pox (Varicella), both after 1st birthday
3 doses of hepatitis B (HBV)
1 dose meningococcal conjugate vaccine (MCV)
   First dose is given at 11-15 years of age
   A second dose is required at age 16 or entry into 12th grade
   If the first dose was given at 16 years of age or older, only one dose is required.

If your child has a medical condition or is in need of medication, please see the nurse, rm. 145.

If you have any questions/concerns please contact the school nurses at 215-400-3200 x 3.

Thank you for ensuring that your child's medical care is up to date.
NORTHEAST HIGH SCHOOL
COTTMAN AND ALGON AVENUES
PHILADELPHIA, PA. 19111

LAST NAME OF STUDENT ____________________________

FIRST ________________________________________ MIDDLE ____________________________ DATE OF BIRTH ____________ GRADE/SECTION ____________

LAST SCHOOL ATTENDED ____________________________

NAME (PARENT OR GUARDIAN) ________________________________________________________________

HOME ADDRESS ____________________________ HOME PHONE ____________________________

MOTHER'S NAME ____________________________ WORK PHONE ____________ CELL ____________

FATHER'S NAME ____________________________ WORK PHONE ____________ CELL ____________

EMERGENCY CONTACT NAME ____________________________ RELATIONSHIP ____________ PHONE ____________

EMERGENCY CONTACT NAME ____________________________ RELATIONSHIP ____________ PHONE ____________

PHYSICIAN NAME ____________________________ ADDRESS ____________________________ PHONE ____________

HEALTH INSURANCE PLAN NAME ____________________________ NUMBER ____________ IF NO INS. CHECK HERE ____________

SPECIAL HEALTH NEEDS

It would be helpful to have the following information so that the school can immediately meet any special health needs of your child.

Has your child ever had any serious illness or operations. Yes No

What? ____________ When? ____________

Is your child going to a hospital, clinic or doctor now? Yes No

What for? ____________ Where? ____________

Apart from vitamins, is your child taking any medicines? Yes No

What? ____________ What for? ____________

Is your child allergic to anything, such as foods, plants, insects, or medicines? Yes No

What? ____________

Does your child have any special health needs or problems the school should know? Yes No

if your child needs to take medication during the school day please see the School Nurse. Medication must be in a labeled container from a pharmacy with child's name, name of medication, dosage, instructions for administration, and your doctor's name. A MED-1 must be on file.

if you have any questions regarding your child's health needs please contact the School Nurse at 215-400-3200, ext #3.
REPORT OF PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>Name of Student</th>
<th>Date of Birth</th>
<th>Student ID #</th>
<th>Grade</th>
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<tr>
<th>Name of School</th>
<th>Room/Section/Book</th>
<th>Date Issued</th>
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<tbody>
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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.

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: ________

RECORD OF VACCINE ADMINISTRATION

Please attach complete immunization record including serology results if available.

- Allergies: ___________  |  Date of last PPD: ________  |  Result: ________

Does this student have health insurance?  __ Yes  __ No  Name of Insurance Provider: ___________________________

RECORD THE FOLLOWING

2. Audiometric Screening: R __ L __ 3. BP: ________
3. Height: ________ Inches / cm  Weight: ________ Lb / Kg  BMI percentile: ________
5. Activity Recommendation:  Full Physical Activity  Restricted Physical Activity
   (Most Complex Phys. Ed. Medical Examinations/Program Modification Form: MEH-31)
   Specify Restrictions: ___________________________
6. List all medications currently being taken:
   Medication: ___________________________  Reason: ___________________________
7. 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: ___________________________ Date of Exam: ________
Address: ___________________________ Care Provider office stamp (REQUIRED): ________

MEH-1 (Rev. 11/12) Comm. Code 51032445214
# REPORT OF PRIVATE DENTAL EXAMINATION

<table>
<thead>
<tr>
<th>Name of School</th>
<th>Student ID</th>
<th>Date Issued</th>
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## TO THE DENTIST

Pennsylvania law requires that students attending school in the Commonwealth receive periodic dental examinations at stated intervals (upon original entry, while in third grade, and while in seventh grade).

These examinations are required for school attendance. Payment for these examinations is the responsibility of the parent/guardian. If the student/family does not have health insurance the school nurse will help the family apply for health insurance. Please attach a copy of the student's dental examination or record the data below.

Thank you for your cooperation.

<table>
<thead>
<tr>
<th>UNDER TREATMENT / WORK BEGUN</th>
<th>COMPLETION OF WORK / NO TREATMENT NECESSARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Work Begun</td>
<td>No Treatment Required Now</td>
</tr>
<tr>
<td>Scheduled Follow-up Appointment</td>
<td>All Necessary Dental Work Completed</td>
</tr>
<tr>
<td>Date of Dental Examination</td>
<td>Expected Completion Date</td>
</tr>
<tr>
<td>Comments / Follow-up Treatment / Special Instructions to School</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Dentist</th>
<th>Telephone</th>
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<table>
<thead>
<tr>
<th>Signature of Dentist</th>
<th>Date Signed</th>
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<thead>
<tr>
<th>Address</th>
<th>Fax Number</th>
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</table>

## IMPORTANT:

Return this form to: Certified School Nurse/Practitioner

School

School Address

Phone Number:
Student Emergency/Medical Information

Last Name: ________________________ First Name: ________________________ DOB: ________________________

School: ____________________________ Room/Sec: ___ Grade: ___

Home Address: ________________________ Home phone: ________________________

Mother: ________________________ email: ________________________ phone: ________________________

Father: ________________________ email: ________________________ phone: ________________________

Guardian: ________________________ email: ________________________ phone: ________________________

Emergency contacts (other than parents) must be local and available for contact:
Name and Relationship to child Phone
1. ________________________
2. ________________________

Child Doctor/Clinic: ________________________ Phone: ________________________

Medical Insurance: MA CHIP Private ________________________

Insurance company name: ________________________ Policy Number: ________________________

Please circle below to give permission to the school nurse to give your child medication:

Acetaminophen (Tylenol) YES NO
Ibuprofen (Advil, Motrin) YES NO

Please CIRCLE the following if your child:
Wears: Glasses Hearing aid
Has: Seizure Diabetes Asthma ADD/ADHD

List Allergies: Food substitution requires a new order yearly from health care provider:

Other Health Problems:

Does your child take medication? __ NO ___ YES (please list)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency/Time</th>
<th>Reason</th>
</tr>
</thead>
</table>

Your signature gives permission for emergency treatment; as well as for SDP School Nurses to administer medications you indicate on this emergency form, during school hours, on field trips and after school activities.
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: ________________________

Revised 5-85 (06/2018)