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)

NORTHEAST HIGH SCHOOL

1601 Cottman Ave.

Philadelphia, PA. 19111

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
1601 COTTMAN AVE.
(COTTMAN & ALGON AVE.)
PHILADELPHIA, PA. 19111

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? What?__________________ Yes No

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 Schol Nurse at 215-400-3200, ext #3.

NORTHEAST HIGH SCHOOL
1601 COTTMAN AVE.
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PHILADELPHIA, PA 19111

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES
REPORT OF PHYSICAL EXAMINATION

Name of Student	Date-of-Birth	Student ID #	Grade
Name of School	Room/Section/Book	Date Issued	

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__________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. Ed. Medical Exemption/Program Modification Form MEH-23)
   Specify Restrictions: __________
7. List all medications currently being taken:
   Medication:__________ 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	

THE SCHOOL DISTRICT OF PHILADELPHIA

NORTHEAST HIGH SCHOOL
1601 COTTMAN AVE.
(COTTMAN & ALGON AVE.)
PHILADELPHIA, PA 19111

REPORT OF PRIVATE DENTAL EXAMINATION

Name of School	Student ID	Date Issued	
Name of Student	Date of Birth	Room/Section/Book	Grade

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.

UNDER TREATMENT / WORK BEGUN	COMPLETION OF WORK / NO TREATMENT NECESSARY
Date Work Begun	☐ No Treatment Required Now
Scheduled Follow-up Appointment	☐ All Necessary Dental Work Completed
Date of Dental Examination	Expected Completion Date
Comments / Follow-up Treatment / Special Instructions to School	

Name of Dentist	Telephone
Signature of Dentist	Date Signed
Address	Fax Number

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.____

Childs 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: Seizures Diabetes Asthma ADHD

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

____

Other Health Problems: ________________________________

____

____

Does your child take medication? ____NO ____YES (please list)

Medication	Dose	Frequency/Time	Reason

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____________