Jersey Shore Area School District
175 A&P Drive, Jersey Shore, PA 17740

Form
9

Medical Forms Cover Letter

In order to get to know your child and complete his/her registration, certain medical forms are necessary. Attached are the following forms that need to be completed for registration:

- Health History (Form A)
- Medical Screening Acknowledgement (Form B)
- Private Physician's Form of Physical Examination (Form C)
  Upon entering into school in **grades K or 1 and in grades 6 and 11**, all students are required by the Pennsylvania State Health Department to have a physical exam. If your child will be seen by your family health care provider, please have the enclosed Commonwealth of Pennsylvania Department of Health Form #H511.336 (JSASD Med. Form C) completed and returned to the school as soon as possible. **The exam must be performed within one year of the start of the school year.**
- Private Dentist's Form of Dental Examination (Form D)
  Upon entering into school in **grades K or 1 and in grades 3 and 7**, all students are required by the Pennsylvania State Health Department to have a dental exam. If your child will be seen by your family dentist, please have the enclosed Commonwealth of Pennsylvania Department of Health Form #H514.027 (JSASD Med. Form D) completed and returned to the school as soon as possible. **The exam must be performed within one year of the start of the school year.**

Please return the completed form(s) to the nurse at your child's school. If you have any questions please contact the school nurse and/or if you prefer to have the form faxed, use the appropriate numbers below:

Senior High	Judy Morlock RN/CSN	Ph: 570-398-7170	Fax: 570-398-5612
Middle School	Judy Morlock RN/CSN	Ph: 570-398-7400	Fax: 570-398-5618
JS ES	Hillary Leonard RN/CSN	Ph: 570-398-7120	Fax: 570-398-5624
Avis ES	Hillary Leonard RN/CSN	Ph: 570-753-5220	Fax: 570-753-3469
Sall ES	Hillary Leonard RN/CSN	Ph: 570-398-2931	Fax: 570-398-5066

Jersey Shore Area School District

175 A&P Drive, Jersey Shore, PA 17740

Med. Form

A

Health History

Name _____ Date of Birth _____

Please check all that apply

Does your child have:			**Has your child had:**			
Cleft Palate/Lip	☐ Yes	☐ No	Broken Bones	☐ Yes	☐ No	
Frequent Sore Throats	☐ Yes	☐ No	Tonsils Removed	☐ Yes	☐ No	
Frequent Earaches	☐ Yes	☐ No	Head Injury(unconscious)	☐ Yes	☐ No	
Frequent Colds	☐ Yes	☐ No	Difficult Sleeping	☐ Yes	☐ No	
Allergies	☐ Yes	☐ No	Convulsions	☐ Yes	☐ No	
Speech Difficulties	☐ Yes	☐ No	Epileptic Seizures	☐ Yes	☐ No	
Chronic Cough	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No	If yes, month/year:_____
Emotional Problems	☐ Yes	☐ No	Measles (Regular/10 Day)	☐ Yes	☐ No	
Bedwetting/Wetting	☐ Yes	☐ No	Measles (German/3 Day)	☐ Yes	☐ No	
Frequent Nightmares	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	
Poor Eating Habits	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No	
Stomach Problems	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No	
Bowel Problems	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	
HIV/AIDS	☐ Yes	☐ No				
Behavioral Problems	☐ Yes	☐ No				
Vision Problems	☐ Yes	☐ No				

Explain all *Yes* answers:_____

_____

_____

Abnormal Birth History:_____

List all operations:_____

List all major illnesses:_____

List all current daily medications, include dose:_____

_____

List all as needed medications, include dose:_____

_____

Is your child presently under medical treatment (if yes, explain):_____

_____

_____

Family History

(Please check those that apply to your family)

☐ Allergies	☐ Epilepsy	☐ Tuberculosis	☐ Heart Disease	☐ Kidney Disease
☐ Asthma	☐ Deafness	☐ Diabetes	☐ Psychiatric Depression	

_____ _____

Parent/Guardian Signature Date

Rev. 12/11

Jersey Shore Area School District
175 A&P Drive, Jersey Shore, PA 17740

Med. Form

B

Medical Screening Acknowledgment

In order to eliminate the need to send home numerous permission slips for the various phases of our school health programs, we are offering this form as an overall coverage for this program.

Student Name _____ Date of Birth _____

I understand my child will participate in the following Pennsylvania State mandated health programs:

- Annual Vision Screening, Grades K-12
- Annual Height and Weight Screening, Grades K-12
- Hearing Screening, Grades, K, 1, 2, 3, 7, and 11
- Scoliosis Screening, Grades 6, and 7
- Physical examinations upon entry into school (Grades K or 1) and Grades 6 and 11*

If you have any questions regarding the school health program, please feel free to call your school nurse.

_____ _____

Signature of parent/guardian Date

*You may have the routine school health examination performed by your family physician at your expense. A private physician's form is enclosed in this packet. If your child is be examined by the school physician, you will be informed when and where the exam will occur. If you wish to attend, contact the school nurse.

pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date_____

Date of birth _____ Age at time of exam_____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: ***Has the student…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: ***Has the student…***	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: ***Has the student...***	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **DURING** or **AFTER** exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: ***Has the student...***	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: ***Has the student…***	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: ***Has the student…***	**YES**	**NO**
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student…***	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student_____ Date_____

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	**CHECK ONE**			***ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS**
	NORMAL	***ABNORMAL**	**DEFER**	
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	**DATE APPLIED**	**DATE READ**	**RESULT/FOLLOW-UP**

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____

Print name of examiner _____

Print examiner's office address_____ **Phone**_____

Signature of examiner_____ **MD ☐ DO ☐ PAC ☐ CRNP ☐**

STUDENT NAME:

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)
STUDENT NAME:

H514.027 (2/2024)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION/SCREENING OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20___

NAME OF STUDENT	DATE OF BIRTH	GRADE	SECTION/ROOM
Last First Middle			

ADDRESS

No. and Street City or Post Office Borough/Township County State Zip

REPORT OF EXAMINATION/SCREENING

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
EXAM	UPPER																	Upper
	LOWER																	Lower

Untreated Decay: No Yes

Treated Decay: No Yes

Sealants on Permanent Molars No Yes

Treatment Urgency: None Early Urgent

_____
Date

_____ _____
Signature of Dental Provider Print Name of Dental Provider

_____
Address of Dental Provider

Jersey Shore Area School District
Authorization for First Aid/Emergency Care

Date _____ Grade _____ Homeroom _____ Birth Date _____

Student Name _____ _____ _____ Phone _____
Last First Middle
Home Address _____ Email _____

Mother's Name _____ Work Place _____ Wk# _____
Cell# _____
Father's Name _____ Work Place _____ Wk# _____
Cell# _____

Child lives with: (please circle) Both Parents Father Mother Guardian Other _____

If school is unable to reach either of the above, please list 2 relatives or friends who you give the authority to advise and/or pick up your child if sick or injured:
Name/Relationship _____ Address _____ Phone _____
Name/Relationship _____ Address _____ Phone _____

First Person to Contact _____

EMERGENCY TREATMENT

List any conditions your child may have, of which the school nurse should be aware: (Ex. Asthma, Seizure Disorder, Depression, Allergies, etc.)

_____

BEE STING REACTION:
Does your child have an allergy to bees which requires emergency medication? Yes No
If yes, please list medication used when stung: _____

PERMISSION TO EXCHANGE INFORMATION:
My child's health and/or medical information may be shared with school staff as needed so that in an emergency the staff can act in the best interest of my child.

_____
Signature Parent/Guardian

EMERGENCY TREATMENT:
If emergency treatment is required, the school authorities will use their judgment in sending the child to the nearest hospital

Acetaminophen (Tylenol), Ibuprofen (Advil), Antacid (Tums):

Non-prescription medications that may be given in a non-emergency situation are Ibuprofen (Such as Advil®/Motrin®), Acetaminophen (such as Tylenol®), Antacids (such as Tums®) in accordance with the treatment protocol established by the school physician. Acetaminophen/Ibuprofen dosage is based on age and weight of the child. When health situations arise for administering these medications **and** the parent/guardian have signed the permission below for their administration, these will be offered to students. The authorization will be in effect the current school year unless revoked by the parents/guardian in writing to the School Nurse.

Tylenol/Advil/Tums need to be supplied by the parent/guardian if taking often OR if Children's dosage (liquid/chewable) is needed.

I agree that the District and its employees are not to be held liable for giving medicine in accordance with this Authorization. I agree to hold harmless and indemnify the Jersey Shore Area School District and all of its employees against any and all claims, damages, expenses, attorney's fees, suits, cause or causes of action which may be brought against the District or its employees in connection with giving such medicine.

_____
Signature Parent/Guardian

Jersey Shore Area School District

LEARNING | GROWING | SUCCEEDING

Permission to Give Prescription Medication at School

*The administration of prescription medication in school is permitted with a **written doctor's order and parent permission.**
***Over the counter medication such as cold and cough medicine, must have a doctor's order and medication stored in nurse office.**
***Sign permission on emergency card for nurse to administer Acetaminophen, Ibuprofen, Tums**
*All prescription medication must be in the original bottle properly labeled.
***With doctor's permission a student may carry their Inhaler and/or EpiPen.**

Student Name_____

Medication	**Dosage**	**Time**	**Route**	**Duration**

Diagnosis_____

Side Effects_____

_____ _____
Physician's Name Printed **Physician's Signature**

_____ _____
Physician's Phone Number **Date**

Parent Permission

I give permission for my child to receive _____ at school as directed by the doctor. (Medication Name)

_____ _____ _____
Parent Signature Date Student Name / Grade / Teacher

I agree that the District and its employees are not to be held liable for giving medicine in accordance with this Authorization. I agree to hold harmless and indemnify the Jersey Shore Area School District and all of its employees against any and all claims, damages, expenses, attorney's fees, suits, cause or causes of action which may be brought against the District or its employees in connection with giving such medicine.

School	**Phone**	**Fax**		**School**	**Phone**	**Fax**
Jersey Shore Elementary	570-398-7120	570-398-5624		**Jersey Shore Middle School**	570-398-7400	570-398-5618
Avis Elementary	570-753-5220	570-753-3460		**Jersey Shore High School**	570-398-7170	570-398-5612
Salladasburg Elementary	570.398.2931	570.398.5066				