

Independence Charter School
SCHOOL HEALTH SERVICES
STUDENT HEALTH STATUS

LAST NAME		FIRST NAME		BIRTH DATE
SCHOOL NAME		ROOM/BOOK	GRADE	DATE OF ISSUE

■ Please complete this form and return it to your school nurse immediately for the safe care of your child.

To Parent/Guardian:

Your child's health record/history indicates that he/she has been under care for the following health problem(s):

1. Does the student's health problem(s) still exist? _____

2. Does he/she have other health problems? Yes No If yes, what are they? _____

3. Does he/she take medicine?
 Yes No
 If yes, please give name of medicine,
 dosage, and time(s).

Medicine	Dosage	Time

4. Does he/she regularly receive treatment/therapy or undergo any testing procedures? _____
 If yes, please indicate kind and how often taken _____

5. Name of doctor, clinic or health center providing care for the student _____
 Address _____
 Phone # _____ Fax # _____ Date of last visit _____

6. Insurance Provider _____

► **CONTACTS:**

Parent/Guardian: _____ Home Phone: _____
 Work Phone: _____ Cell/Pager: _____
 Parent/Guardian: _____ Home Phone: _____
 Work Phone: _____ Cell/Pager: _____
 Emergency Contact #1: _____ Phone #: _____
 Emergency Contact #2: _____ Phone #: _____

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 _____ Date _____

TO SCHOOL STAFF: SEE REVERSE SIDE FOR EMERGENCY CARE

SCHOOL NURSE	PHONE #
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Independence Charter School
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.

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 <small>(Must Complete Phys. Ed. Medical Exemption/Program Modification Form MEH-23)</small>
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	Care Provider office stamp (REQUIRED)
	Fax	
Address	Date of Exam	

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		<input type="checkbox"/> M <input type="checkbox"/> F		

ADDRESS _____

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