City of Philadelphia
DEPARTMENT OF PUBLIC HEALTH
Division of Disease Control

Philadelphia Immunization Requirements for School Entry (2018/2019)

Vaccines are required on the first day of school

A child must have at least one dose of all vaccinations, or risk exclusion.
A child may have a documented medical, religious, or philosophical exemption from these vaccinations.
Even if exempt, a child may be excluded from school during an outbreak of vaccine-preventable disease.

If a child doesn't have all required doses of a vaccine, she/he must within the first 5 days of school:

Receive the next dose, if medically appropriate.
Have a parent/guardian provide a medical plan, if the next dose isn't the final dose of the series.
Have a parent/guardian provide a medical plan, if the next dose is not medically appropriate.

Required on the first day of school:

All Grades	Doses	Notes
Tetanus, diphtheria, pertussis (DTP/Dtap/DT/Td, or Tdap)	4*	1 dose on or after age 4 years
Polio (OPV/IPV)	4	4th dose on or after age 4 years, at least 6 months after previous dose**
Measles, mumps, rubella (MMR/MMRV)	2	On or after age 1 year
Hepatitis B (HBV)	3	
Chickenpox (Varicella/MMRV)	2	On or after age 1 year***

7th grade	Doses	Notes
Meningococcal conjugate vaccine (MCV4)	1	On or after age 2 years
Tetanus, diphtheria, pertussis (Tdap)	1	On or after age 7 years

12th grade	Doses	Notes
Meningococcal conjugate vaccine (MCV4)	2	If 1st dose given at age 16 years or older, only 1 dose is needed to enter 12th grade

* *Only 3 doses of Td-containing vaccine are necessary if series started on or after age 7 yrs and at least one dose is Tdap*

** *A 4th dose is not necessary if 3rd dose was given at age 4 years or older and at least 6 months after the previous dose*

*** *Or documentation of immunity by lab test or written statement from parent, guardian, or physician*

Reference: The Pennsylvania Code – Subchapter C. *IMMUNIZATION* §23.81, and from the Philadelphia Board of Health *Regulations Governing the Health of Newborns, Children and Adolescents*, published 2017.

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	

THE SCHOOL DISTRICT OF PHILADELPHIA

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

THE SCHOOL DISTRICT OF PHILADELPHIA

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 (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.

THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REQUEST FOR ADMINISTRATION OF 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 SCHOOL NURSE _____

TELEPHONE NUMBER OF SCHOOL NURSE _____

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.

. Thank you.

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 SCHOOL NURSE _____

TELEPHONE NUMBER OF SCHOOL NURSE _____

. **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.

THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

REQUEST FOR ADMINISTRATION OF SEIZURE 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 SCHOOL NURSE _____

TELEPHONE NUMBER OF SCHOOL NURSE _____

Basic Seizure First Aid:

- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Notify Certified School Nurse
- ✓ Stay with child until fully conscious

For tonic-clonic (grand mal) seizure:

- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

A Seizure is generally considered an Emergency when:

- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

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.

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- 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.