Welcome to Central High School Nurses' Office!

What forms does your child need to attend Central High School?

- MEH 1 – Report of Physical Examination
- S865 - Student Emergency/Medical Information form
  - Gives permission for the nurses to give acetaminophen (Tylenol) and ibuprofen (Motrin/Advil)
- Immunizations
- MED 1* – Request for Administration of Medication
  - Only necessary for conditions that require medications to be taken in school (this includes diabetes medication and supplies, asthma inhalers, and EPI-pens. Students may self-carry these medications and may also keep a supply in the nurses' office).
- Covid consent form
- Forms are due on the first day of school!

What else do you need to know about the nurses' office?

- Students must have a hall pass signed by their teacher to see the school nurse (unless it's their lunch).
- If a student visits the nurse, they may potentially need to be dismissed from school.
  - Students will **NOT** be permitted to leave on their own, they must be signed out by an adult designated on an Emergency Contact form. Please be sure to list any and all adults that might be available to pick up your student during the school day.
- Students who become ill or injured at home should seek care from their primary care provider.
  - Fever greater than 100°F should stay home until they are fever free for 24 hours without using fever reducing medications
  - Students who need to use the elevator must submit medical documentation to the nurses

*The only over the counter medications in the nurses' office are acetaminophen, ibuprofen and hydrocortisone cream. All others require an MED1. Nurses are prohibited from keeping any other medications including allergy, cold, and stomach medicines. **See attached medication policy.**

Parent completes this form

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.

Parent/Guardian Signature_____ Date_____

Revised S-865 (06/2019)

Forms are due by the first day of school.

Doctor completes this form

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 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	

MEH-1 (Rev. 7/19) Comm. Code 61602445214

Forms are due by the first day of school.

Doctor completes this form

SCHOOL DISTRICT QF PHILADELPHIA
CENTRAL HIGH SCHOOL
IMMUNIZATION RECORD

NO student will be admitted with an incomplete immunization record per the State of Pennsylvania and may be sent home the first day of school by the school nurse.

_____ _____
Name Current School

_____ _____ _____
Date of Birth ID Number Grade

IMMUNIZATIONS REQUIRED (may attached printed record):

VACCINE Circle appropriate item	Enter month, day, and year when immunization doses listed below were given.				
Diphtheria, tetanus and acellular pertussis (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, diphtheria and acellular pertussis (Tdap)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	or Measles serology Date		Titer
Varicella (vaccine or disease)	1 / /	2 / /	Rubella serology Date		Titer
Meningococcal (MCV)	1 / /	2 / /			
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		

One dose of DTaP must be on or after the fourth (4th) birthday.
One dose of Polio must be on or after the fourth (4th) birthday.
First doses of MMR and Varicella must be on or after the first (1st) birthday and the second dose should be at least one month after the first dose.

Children not immunized must provide an immunization exemption form available from your school nurse or the School District website.

_____ _____ _____
Date Signed Doctor's Signature Doctor's Phone Number

_____ _____ _____
Date Signed Parent or Guardian Signature Home Phone

Forms are due by the first day of school.

Parent completes this form

THE SCHOOL DISTRICT OF PHILADELPHIA

TO BE COMPLETED BY PARENT/GUARDIAN	
Parent/Guardian Information You will be notified of test results within 1 hour either via cell phone or email, or both. Please make sure your contact information is up to date.	
Parent/Guardian Name:	
Parent/Guardian Cell/Mobile #: Note: results will be sent to this cell#	
Parent/Guardian Email Address: Note: results will be sent to this address	
Child/Student Information	
Child/Student Name:	
Student ID Number:	
School:	
Grade:	
Child's Date of Birth (MM/DD/YYYY):	

Please select the testing model you are consenting to:

- ☐ **Symptomatic Testing** - provided onsite in schools by School Nurse or Testing Vendor
- ☐ **Test to Play/Perform** - REQUIRED for participation in Athletics and Performing Arts
- ☐ **Test to Stay** - In times of low community transmission, this model reduces the need to quarantine.

By signing below, I consent to follow and understand that my child must follow School District of Philadelphia Health and Safety protocols, consent to my child's being tested through the testing models checked off above, consent to test results being shared with me at the phone number and/or email address provided above, and also and agree to the following:

- I am signing this form freely and voluntarily and I am the parent or legal guardian of and am authorized to make decisions for the child named above.
- I understand that my student's test results and related information will be forwarded securely to the Philadelphia Department of Public Health, the Pennsylvania Department of Health, and the Centers for Disease Control in accordance with communicable disease reporting.
- I understand that my student's test results will be shared with the student's athletic director, coach, performing arts instructor, or other school official necessary to monitor compliance with the testing requirements.
- I understand that the School District of Philadelphia, school nurse, and/or testing partner are not acting as my child's medical provider and that this testing does not replace treatment by my child's medical provider, and I assume complete and full responsibility to follow up with a medical provider to determine appropriate action with regard to my child's test results.

Date: _____ **Parent/Guardian Signature:** _____

Forms are due by the first day of school.

Policy for Students Receiving Medication in School

- Acetaminophen (Tylenol, up to 1000mg) or ibuprofen (Advil/Motrin, up to 400mg) can be administered by the School Nurse only if a completed S865 Student Emergency/Medical Information form has been signed by a parent or guardian and submitted to the Nurses' office. If your student requires acetaminophen or ibuprofen in doses higher than indicated, a MED1 Request for Administration of Medication is required.
- All students receiving prescribed medications or other over the counter medications not indicated above require an MED1 Request for Administration of Medication form to be filled out by a medical provider.
  - A new form must be completed each school year and includes asthma inhalers, diabetes medications and supplies, and EpiPens.
- Any medication that your student may need during the school year (except acetaminophen and ibuprofen) must be provided to the nurses in the original packaging with the student's name, date of birth or student ID#, and medication name. Prescription medications must be in the proper prescription bottle.
- Over the counter medications (such as allergy medication, cough/cold medicine, vitamins, pain relievers, etc.) are not permitted to be carried in school. Students caught taking medication that was not approved by the nurses may face disciplinary action.
- Students who have medical conditions that require that they carry their own prescribed medication are encouraged to keep extra medication/supplies in the nurses' office in the event that they forget, lose, or otherwise are unable to access their own supply.
- Prescribed medications will be administered by a School Nurse as directed. In the event that the nurse is not present, a substitute nurse or nurse from another school may be available to administer prescribed medications. If no nurse is available to cover school that day, a parent/guardian may be asked to come to school to administer medication to their child.

If you have any questions or concerns, please contact the Nurses' Office at 215-400-3590 option 2. Thank you and let's have a great school year!