South Hills Catholic Academy

STUDENT HEALTH HISTORY

Student's Name _____ Grade _____ Date of Birth _____

Street Address _____

City _____ Zip _____ Cell/Primary Phone _____

Siblings Name	Birth Date	School	Grade

Name and address of school last attended:

Name of School:

Address of School:

Physician: _____ **Phone Number** _____

Dentist: _____ **Phone Number** _____

Medication: (please list all medications taken):

At Home: _____

At School: _____

*(If required at school, complete form #**440-Authorization for Medicine**)*

OVER

STUDENT NAME: _____ **GRADE** _____

TO BE COMPLETED BY PARENT/GUARDIAN

Please check ✓ ALL that applies to your child

Anxiety	☐	*Developmental Delay*	☐	*Nosebleeds*	☐
Arthritis	☐	*Diabetes Type 1*	☐	*Orthopedic Condition*	☐
Asthma	☐	*Diabetes Type 2*	☐	*Rheumatic Disease*	☐
Attention Deficit Disorder	☐	*Dietary Restrictions*	☐	*Sickle Cell*	☐
Autoimmune Disorder	☐	*Epilepsy/Seizure Disorder*	☐	*Speech Difficulty*	☐
Bladder/Bowel Control	☐	*Gastrointestinal Condition*	☐	*Spina Bifida*	☐
Bleeding Disorder	☐	*Hearing Deficit – right / left*	☐	*TB Exposure*	☐
Blood Pressure Issues – high or low	☐	*Immunocompromised*	☐	*Thyroid Condition – Specify*	☐
Cancer	☐	*Inflammatory Bowel Disease*	☐	*Tourette's Syndrome*	☐
Cardiovascular Condition – Specify	☐	*Kidney Condition*	☐	*Vision: Eye Surgery – Specify*	☐
Cerebral Palsy	☐	*Mental Health Diagnosis*	☐	*Severe Vision Loss – right / left*	☐
Chicken Pox (date)	☐	*Migraines*	☐		
Color Vision Deficiency	☐	*Neurological Disorder*	☐		
Dental Condition	☐		☐		

Explain Above Check Marks: _____

Allergies/Reaction: _____

Previous Surgeries/Dates: _____

Other: _____

I understand and agree that any and all of this information may be shared with appropriate school personnel.

_____ _____

Parent/Guardian Signature Date

_____ _____

Signature of Certified School Nurse Date

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 ☐ Asthma/lung problems ☐ Behavioral health issue ☐ Diabetes ☐ Inherited disease/syndrome ☐ Kidney problems ☐ Seizure disorder ☐ 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 ☐ Cardiomyopathy ☐ High blood pressure ☐ High cholesterol ☐ QT syndrome ☐ Marfan syndrome ☐ Ventricular tachycardia ☐ 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: *L*	**ABNORMAL*	*DEFER*	***ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS**
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(8/2011-under review)

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
				☐ M ☐ F		
Last	First	Middle				

ADDRESS

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

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 1	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 Exam

_____ _____
Signature of Dental Examiner Print name of Dental Examiner

_____
Address

South Hills Catholic Academy

Authorization for Medication

Dear Parent/Guardian:

For safety reasons, the administration of student medicines, either prescription or non-prescription, during school hours is strongly discouraged.

If a physician deems it necessary for your child to take medications, either prescription or nonprescription during the school day, the **AUTHORIZATION FOR MEDICATION FORM** (reverse side) must be completed by **both** a parent/guardian and physician and returned to your child's health office prior to any medication being administered.

The following summarizes the procedure:

- Physician orders MUST be completed and dated July 1st or after for the upcoming school year.
- Prescription medication must be in the current and appropriate labeled pharmacy container. The order and the pharmacy bottle must match.
- Over the counter medication (nonprescription) must be in the original, unopened container and the type of non-prescription medication must match the physician's orders.
- A new form completed by both the physician and parent/guardian is required for each medication,medication change, dose change, and for each new school year, dated July 1st or after for the upcoming school year
- It is the responsibility of your child to report to the health office for his/her medication.

Please remember that your child may not receive his/her medication if these procedures are not followed.

Please feel free to contact the school office if you have any questions or concerns regarding this matter.

Thank you for your cooperation.

South Hills Catholic Academy

South Hills Catholic Academy

Authorization for Medication, Prescription and
Non-Prescription to be Given During School Hours

Student's Name:_____ ID# _____School_____

Date of Birth_____ Sex_____ Grade/Homeroom_____

Physician's Name_____ Office Phone Number_____

TO BE COMPLETED BY LICENSED PRESCRIBER:

MEDICATION	
DOSAGE	
TIME OF ADMINISTRATION; daily or PRN (how often)	
LENGTH OF ADMINISTRATION (i.e. the school year or a shorter time)	
REASON FOR MEDICATION	
ADMINISTRATION INSTRUCTIONS	
SIDE EFFECTS	
SIGNATURE OF LICENSED PRESCRIBER	
DATE	

TO BE COMPLETED BY PARENT/GUARDIAN:

In consideration of South Hills Catholic Academy (SHCA) granting our request to dispense certain medication to our child, the undersigned parents/guardians, on our own behalf and on behalf of our minor child, hereby release, indemnify and hold harmless South Hills Catholic Academy and its School Board, Administrators, Teachers, Secretaries, Nurses and Employees from and against any and all claims, damages, actions or causes of action resulting and/or arising out of or connected directly or indirectly with the request for or the dispensing of medication listed above to our said child. **I understand and agree the medical information may be shared with appropriate personnel. I authorize my child's physician to release any medical information that may be required by SHCA personnel. I understand and agree that emergency medication may be administered by SHCA employees who are not nurses.**

Parent/Guardian signature_____ Date_____

Home Phone #_____Work #_____Cell #_____