TULPEHOCKEN SCHOOL DISTRICT

TULPEHOCKEN AREA SCHOOL DISTRICT
27 Rehrersburg Road Bethel, PA 19507

Bethel Elementary (717) 933-4131 FAX (717) 933-8485
Penn-Bernville Elementary (610) 488-6248 FAX (610) 488-1188
Tulpehocken Jr./Sr. High School (610) 488-6286 FAX (610) 488-7976

AUTHORIZATION FOR SCHOOL MEDICATION ADMINISTRATION
FORM MUST BE COMPLETED BY BOTH A PHYSICIAN AND PARENT

Child's Full Name:_____ Grade/Homeroom: _____

Date of Birth: _____ Drug Allergies: _____

PHYSICIAN'S REQUEST

Name of medication: _____

Reason: _____

Side effects and/or limitations on activities: _____

Time and dose(s) to be given at home: _____

Time and dose(s) to be given at school: _____

Medication is to be administered:

1. _____until completed. Dates to be given at school: _____
2. _____entire school year. Daily_____ PRN_____
3. _____other: _____

_____ I believe this child is able and responsible to carry and self-administer his/her inhaler (grades K-12) and/or Epi-Pen (grades 7-12) during school. He/she has permission to do so and has been instructed on how to self-administer.

_____ _____
Physician Signature **Printed Name**

_____ _____
Date **Phone Number**

PARENT'S REQUEST

I, the parent/guardian of _____ request that the employees (nurse, principal, or principal designee) of the Tulpehocken Area School District administer the above named medication as prescribed by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Tulpehocken Area School District and its Board of Directors and all employees unless the District is negligent with regard to any claim for injury in connection with administration of medication.

Additionally, I agree to hand deliver the medication to the nursing office in the original pharmacy or physician labeled container. I also accept responsibility to provide a physician's note and my written instruction if the medication is to be changed or discontinued. I give permission for the school and physician to communicate regarding this medication and medical condition.

_____I believe my child is able and responsible to carry and self-administer his/her inhaler (grades K-12) and/or Epi-Pen (grades 7-12) during school activities. I give permission for him/her to do so and he/she has been instructed on how to self-administer. If my child uses his/her inhaler or Epi-Pen, he/she will notify the nurse as soon as possible after using the medication.

_____ _____
Parent/Guardian Signature **Date**

List all medications currently being taken by this child_____

TULPEHOCKEN SCHOOL DISTRICT

TULPEHOCKEN AREA SCHOOL DISTRICT
27 Rehrersburg Road Bethel, PA 19507

Bethel Elementary (717) 933-4131 FAX (717) 933-8485
Penn-Bernville Elementary (610) 488-6248 FAX (610) 488-1188
Tulpehocken Jr./Sr. High School (610) 488-6286 FAX (610) 488-7976

PARENT NOTIFICATION OF MEDICATION PROCEDURE

★ This must be done annually to cover one school year (August-June) ★

It is our intent to ensure the maximum health and safety for all students in the Tulpehocken Area School District. We realize that at times students have medical conditions which require the use of medication. In most situations, all doses of the prescribed medications can be given at home; however, there are times when it will be necessary for a student to receive medication during school hours.

The following procedures are necessary in order to comply with Pennsylvania State laws, including those of the State Board of Nurse Examiners. Please review the following guidelines carefully and consult the nurse in your child's school if you have any questions.

When it is necessary for a student to receive **ANY** medication(s) (including over-the-counter medications) at school, **PARENT/GUARDIAN MUST**:

1. Complete the form *"Authorization for School Medication Administration"* which requires both **PARENT/GUARDIAN** and **PHYSICIAN** signatures. A copy of this form is attached. Additional copies can be obtained from the nurse's office or on the Tulpehocken District website – www.tulpehocken.org Photocopies of the physician's signed original prescription form are acceptable as are faxed medication orders.

   MEDICATION(S) CANNOT BE GIVEN UNTIL WRITTEN PERMISSION IS OBTAINED FROM BOTH THE PARENT/GUARDIAN AND PHYSICIAN.

2. A parent/guardian shall **HAND DELIVER** the medication to the school nurse in the labeled prescription container and/or original over-the-counter container. Upon request, most pharmacists will provide two labeled containers for a prescription so that one can be brought to school containing the number of doses required to be administered during school hours. The parent/guardian or adult designee will count and confirm the number of pills with the school nurse.

3. Notify the school nurse with a physician's order and your written consent if the medication is to be changed or discontinued.

4. Medications not picked up by the parent/guardian by the end of the school year will be discarded.

If these procedures are not followed, the school nurse will not be able to administer the medication during school hours. We regret any inconvenience this may cause you, but we feel these cooperative efforts are necessary to ensure the health and safety of our students. As always, your inquiries to the school nurse are welcomed if clarification is needed.

Sincerely,
TASD School Nurses

Enc. - Authorization form
Instructional Support Services 9/12

H511/336 (Rev. 5/02)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

DATE _____ 20 ____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD	DATE OF BIRTH	SEX
Last First Middle		☐ M ☐ F

ADDRESS

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

MEDICAL HISTORY

IMMUNIZATIONS AND TESTS

VACCINE	Enter Month, Day and Year Each Immunization Was Given DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, Td	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	Varicella Disease or Lab Evidence Date: _____		
Other_____					

☐ **MEDICAL EXEMPTION** The physical condition of the above named child is such that immunization would endanger life or health

☐ **RELIGIOUS EXEMPTION** (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

If Applicable:

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	**Results (mm)**		**Signature**		

Follow-Up of significant tuberculin tests:

Parent/Guardian notified of significant findings on. _____ Date

Results of Diagnostic Studies: _____ Date

Preventive Anti-Tuberculosis – Chemotherapy ordered. ☐ NO ☐ YES _____ Date

(Continued on Back)

Significant Medical Conditions (✓)

	Yes	No	If Yes, Explain
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might effect his/her education? If so, specify.

Report of Physical Examination (✓)

	Normal	Abnormal	Not Examined	Comments
• Height (inches)				
• Weight (pounds) BMI				
• Pulse ( )				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes/Vision				
• Ears/Hearing				
• Nose and Throat				
• Teeth & Gingiva				
• Lymph Glands				
• Heart – Murmur, etc.				
• Lung – Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

Date of Examination

Signature of Examiner

PRINT Name of Examiner

Address

Telephone Number

H514.027 (08/2011)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

SCHOOL DENTAL HEALTH RECORD

SCHOOL DISTRICT			COUNTY	DATE OF BIRTH	
NAME OF STUDENT	LAST	FIRST	MIDDLE	GRADE	SEX M☐ F☐
HOME ADDRESS					TELEPHONE NO.

THE ABOVE INFORMATION SHOULD BE FILLED IN BEFORE THE EXAMINATION OR EVALUATION

Record on Dental Chart **d** (Decayed), **e** (indicated for extraction), and **f** (filled) for deciduous teeth and **D** (Decayed), **M** (Missing), and **F** (Filled) for permanent teeth.

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
First Exam	Upper																	UPPER
	Lower																	LOWER
Second Exam	Upper																	UPPER
	Lower																	LOWER
Third Exam	Upper																	UPPER
	Lower																	LOWER
Fourth Exam	Upper																	UPPER
	Lower																	LOWER
Fifth Exam	Upper																	UPPER
	Lower																	LOWER

STUDENT REFERRAL

DATE	EXAMINED OR EVALUATED BY	REFERRED TO	REMARKS