Saints John Neumann and Maria Goretti Catholic High School

1736 SOUTH TENTH STREET
PHILADELPHIA, PA 19148-1694
Phone (215) 465-8437 Fax (215) 462-2410
www.neumanngorettihs.org

Dear Parents of **ALL 9th grade** students and **NEW students** in grades **10, 11 and 12**:

In preparation for this school year, the following forms are required to be completed for ALL students entering the 9th grade or all NEW upperclass students to SS. John Neumann and Maria Goretti Catholic High School. All forms are due to the school nurse on or before September 11, 2017.

Pennsylvania State Law requires that students have a physical examination as well as a dental examination upon entry to the 9th grade or registration in a new school. **Both physical and dental exams need a current date of July 2017 or later.** All students are required to have a complete immunization record on file -- using the guidelines of the Philadelphia Department of Health and the School District. Please note that a second (2nd) Varicella Vaccine, at age 14 for those who have not had chicken pox is required; Mantoux (tuberculin testing) must be updated every ten years; 12th grade students are required to have a second Meningococcal Conjugate Vaccine(MCV4 #2). The following forms are included:

1. **REPORT OF PHYSICAL EXAMINATION** (white form) -- BOTH sides to be completed and stamped by the student's primary care physician, this should include a record of immunizations.
2. **REPORT OF PRIVATE DENTAL EXAMINATION** (white form) -- to be completed and stamped by the student's dentist.
3. **STUDENT MEDICAL HISTORY** (pink form) -- to be completed by the parent/guardian.
4. **STUDENT EMERGENCY INFORMATION** (gray form) -- to be completed by parent/guardian.

The **WHITE FORMS** are for your doctor and dentist to complete. **Please be sure that these forms are signed by the doctor and dentist, and that the doctor's name, address and phone number are stamped clearly on the forms -- this is required on ALL medical forms.** The **PINK and GRAY FORMS** are for you, the parent, to give a brief health history and emergency information.

As the school nurse of SS. John Neumann and Maria Goretti Catholic High School, I am committed to making sure that all of our students' health care needs are being met. Please be advised that all medical information is required by the Commonwealth of Pennsylvania. Parents/guardians are required by the state to submit all medical records requested. Record requirements are due on or before **September 11, 2017. Failure to submit the requested requirements will result in your son/daughter being excluded from school until the information is received. Be sure the student's name is on all five forms when they are returned during the summer or in September.**

If your child does not have a primary health care provider or health insurance, you can contact **Philadelphia Citizens for Children and Youth (PCCY), at 215-563-5848 ext. 19** or **The Caring Foundation for Children at 1-800-464-KIDS** for free or low cost health insurance programs.

Thank you for your cooperation and have a wonderful vacation!

Sincerely,

Amy Boyd, RN -- School Nurse

DEPARTMENT OF PUBLIC HEALTH

City of Philadelphia
Department of Public Health
Division of Disease Control
Immunization Program

Philadelphia Immunization Requirements for School Entry (2017/2018)

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

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

7th grade	Doses	Notes
Meningococcal conjugate vaccine (MCV4)	1	At/after age 2
Tetanus, diptheria, pertussis (Tdap)	1	At/after age 7

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

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

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

If a child doesn't have required doses, they 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

Reference: The Pennsylvania Code – Subchapter C. *IMMUNIZATION* §23.81, amended May 28, 2010, effective August 1, 2011, and from the Philadelphia Board of Health *Regulations Governing the Health of Newborns, Children and Adolescents*, published 2009.

To be completed by Doctor. . .

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES
REPORT OF PHYSICAL EXAMINATION

Name of Student	Date of Birth	Student ID #	Grade
Name of School **Neumann-Goretti High School**	Room/Section/Book	Date Issued **September 2017**	

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 **X** _____ 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. 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:

Must be stamped by Doctor's office. . .

Signature of Care Provider (REQUIRED)	Telephone Fax
Address	Date of Exam

MEH-1 (Rev. 11/12) Comm. Code 61602445214

OVER

Please attach a copy of all immunizations

CERTIFICATE OF IMMUNIZATION

Name _____ Birthdate _____

Address _____ Parent or guardian _____

_____ Telephone _____

Race/ethnicity: ☐ White ☐ Black ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native

Hispanic origin: ☐ Yes ☐ No

Please circle present grade. K 1 2 3 4 5 6 7 8 9 10 11 12 Other _____

PENNSYLVANIA DEPARTMENT OF HEALTH – CERTIFICATE OF IMMUNIZATION

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		

H502 320 Rev. 03/17

OR

MEDICAL CERTIFICATE

PLAN

PENNSYLVANIA DEPARTMENT OF HEALTH – MEDICAL CERTIFICATE

Name _____ Birthdate _____

Address _____ Parent or Guardian _____

_____ Telephone _____

Please circle present grade: K 1 2 3 4 5 6 7 8 9 10 11 12 Other _____

VACCINE Circle appropriate item	Enter month, day and year each immunization will be given DOSES				
Diphtheria, tetanus and acellular pertussis (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, diphteria 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	1 / /	2 / /	Rubella serology Date		Titer
Meningococcal (MCV)	1 / /	2 / /			
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		

Attach EHR of vaccines already given.

X _____

Signature (PLEASE CIRCLE - physician, certified registered nurse practitioner, physician assistant, local health department)

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THE SCHOOL DISTRICT OF PHILADELPHIA

STUDENT MEDICAL HISTORY

To be completed by Parent. . .

Name of Student	Date of Birth	Date
		September 2017
Name of School	**Room/Book/Section**	**Grade**
Neumann-Goretti High School		

Dear Parent/Guardian:

Pennsylvania law requires that all children must have a complete checkup when entering school for the first time and again in middle and high school.

The school nurse can help you with information regarding health insurance. There are free and low-cost insurance plans for which your family may qualify. Please take the attached form to your doctor or clinic when you take your child for this checkup and return the completed form to the school nurse by_____

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply asneeded regarding my child's care.

Parent/Guardian Signature X_____ ***Date***_____

STUDENT'S MEDICAL HISTORY - TO BE COMPLETED BY PARENT/GUARDIAN

1. Do you have health insurance? ___ Yes ___ No What is the name of your insurance?_____
2. Where do you take your child for checkups?_____ Phone:_____ Fax:_____
3. Date of child's last physical examination?_____
4. Where do you take your child for dental care? _____ Phone:_____ Fax:_____
5. Date of child's last dental examination?_____
6. Does your child take any medicine now? ___ Yes ___ No, If yes, list below:
   - Medicine:_____ How often _____ For what _____
   - Medicine:_____ How often _____ For what _____
   - Medicine:_____ How often _____ For what _____
7. Is your child allergic to anything? ___ Yes ___ No, If yes, to what_____
8. Does your child have any activity restrictions? ___ Yes ___ No, If yes, explain_____

PLEASE CHECK ANY PROBLEM YOUR CHILD HAS/HAS HAD

__ Asthma	__ Dental	__ High Blood Pressure	__ Physical Disability
__ Anemia	__ Diabetes	__ Hospitalized (Surgery)	__ Premature Birth (Under 5 Lbs)
__ Arthritis	__ Drug/Alcohol	__ Learning Problem	__ Seizures
__ Behavior/Emotional	__ Eczema	__ Lung Disease	__ Speech Difficulty
__ Blood Disorders	__ Frequent Colds	__ Lead Poisoning	__ Tuberculosis
__ Cancer	__ Hearing Difficulty	__ Meningitis	__ Vision Problems
__ Chicken Pox at age___	__ Heart	__ Muscle/Bone/Joint	__ Urinating/Kidney Problem

*Additional comments:*_____

_____

_____

THE SCHOOL DISTRICT OF PHILADELPHIA

To be completed by Dentist. . .

REPORT OF PRIVATE DENTAL EXAMINATION

Name of School	Student ID	Date Issued	
Neumann-Goretti High School		**September 2017**	
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

Must be stamped by Dentist's office

Name of Dentist	Telephone
Signature of Dentist	Date Signed
Address	Fax Number

IMPORTANT:

Return this form to:

Wanda Myers RN
Certified School Nurse/Practitioner

Neumann-Goretti High School
School

1736 S. 10th Street
School Address

215 465-8437
Phone Number

SS. JOHN NEUMANN AND MARIA GORETTI CATHOLIC HIGH SCHOOL
1736 South Tenth Street
Philadelphia, PA 19148-1694
215-465-8437 Fax: 215 462-2410

TO BE COMPLETED BY PARENT/GUARDIAN

Student Emergency Information (please print clearly)

Student's Name: _____
(Last) (First) (Middle)

Gender:_____M_____F Grade: _____ Homeroom Section: _____

Address_____ Home Phone _____

City _____ State _____ Zip Code _____

Mother's Name _____

- Work Phone: _____
- Cell Phone: _____

Father's Name _____

- Work Phone: _____
- Cell Phone: _____

If unable to reach the parent in the event of illness and/or accident, the school is authorized to release the student to the following adult(s):

1. Name _____Relationship _____
   - Phone Number _____
   - Cell Phone _____
2. Name _____ Relationship_____
   - Phone Number: _____
   - Cell Phone: _____

Does your daughter/son have any health needs or problems the school should know?
Yes _____No_____
If YES, please list _____

Does your daughter/son need to take any medication at home? _____Yes _____No

If YES, please list _____

Does your daughter/son need to take medication *at school*? _____Yes _____No
If YES, please list _____
_____

Does your daughter/son have medical insurance at this time? _____Yes _____No
If YES, what is the name of the insurance? _____

Physician's Name _____ Phone Number _____
Dentist's Name _____ Phone Number _____

Parent's Signature X_____ Date _____

You must return this form to the School Nurse by September 11, 2017
(updated form is required each school year)