CHECKLIST OF ITEMS NEEDED FOR KINDERGARTEN REGISTRATION DAY

_____ COPY OF IMMUNIZATION RECORDS

_____ PHYSICAL EXAMINATION (IF DONE)

_____ DENTAL EXAM (IF DONE)

_____ INFORMATION FOR MEDICAL EMERGENCIES

_____ STUDENTS HEALTH HISTORY FORM AND SIGNATURE PAGE

_____ **STATE CERTIFIED** BIRTH CERTIFICATE

_____ PROOF OF RESIDENCY (BILL STATEMENT WITH NAME AND ADDRESS)

_____VISION SCREENING CONSENT FORM

SCHOOL EXCLUSION GUIDELINES

The decision to exclude students who have an infectious disease should be made in conjunction with the school, health care providers, parents and/or the school nurse. Students should be allowed to return to school once the exclusion period is met or a health care provider clears the student. Generally, if any of the following conditions apply, exclusion from school should be considered:

- ✓ If the student does not feel well enough to participate comfortable I usual activities.
- ✓ If the student requires more care than school personnel are able to provide.
- ✓ If the student has a high fever, behavior changes, persistent crying, difficulty breathing, lack of energy, uncontrolled coughing or other signs suggesting a possibly severe illness.
- ✓ If the student is ill with a potentially contagious illness and exclusion is recommended by a health care provider, state or local agency, or these guidelines**

ILLNESS OR SYMPTOM	EXCLUSION GUIDELINES
Chicken Pox	Exclude until **ALL** blisters have erupted & crusted over.
Common Cold	**No exclusion necessary** unless symptoms are severe.
Cough (Significant) Uncontrolled coughing; wheezing; rapid or difficulty breathing	**Exclude**, medical attention is necessary. **Note**: Students with **Stable** asthma may be cared for with a written health care plan and authorized for treatment.
Diarrhea	**Exclude** if, it is causing toilet trained students to have accidents or exceeds 2 or more loose stools.
Fever (defined as temp >100.0)	**Exclude** until fever is <100.0 for 24hours without the use of medications like Tylenol or Motrin.
Fifth's Disease-common viral infection with rash occurring 1-3 weeks after infection	**No exclusion** is necessary , unless other symptoms such as significant fatigue, etc.
Hand foot and Mouth Disease-viral infection that may cause blisters in the mouth, and on hands and feet.	**No exclusion** is necessary, unless other symptoms.
Head Lice	**Exclude** until **ALL** lice and nits are gone. Students are given 3 excused days to treat, and must report to nurse with parent prior to returning to school.
Cold Sores, Fever blisters	**No exclusion** unless the student is drooling.
Impetigo-skin infection caused by streptococcal or staphylococcal bacteria.	**Exclude** until 24 hours after medical treatment is started.
Pink Eye (Conjunctivitis)-Pink or red color of white of the eye and thick yellow/green discharge.	**Exclude** (bacterial or viral), until 24 hours after medical treatment has started.
Rash with fever, behavior change, joint pain, oozing rash, etc.	**Exclusion** is recommended if the student has other symptoms in addition to the rash.
Ringworm-fungal infection that may affect the body, feet, or scalp.	**Exclude** from the end of the school day until after first medical treatment.
Shingles	**No exclusion** is necessary, as long as blisters are covered.
Stomach Ache/Abdominal Pain	**Exclude** if pain is severe; if pain occurs after an injury; or if the student has other symptoms in addition to stomach ache
Strep Throat	**Exclude** until 24 hours after medical treatment started.
Vomiting	**Exclude** until vomiting has resolved.
Whooping Cough (Pertussis)-bacterial infection, ranges from mild cough to severe disease.	**Exclude** until 5 days after medical treatment or 3 weeks after cough onset.

*****If your child becomes ill at school and needs to return home, the school nurse will notify parents/guardians. If notified of illness, please arrange to pick up your child right away.**

PLEASE COMPLETE, SIGN, AND RETURN

INFORMATION FOR STUDENT MEDICAL EMERGENCIES

NAME_____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

ADDRESS_____
Date of Birth_____ Homeroom Teacher_____Present Grade_____
Sex ( ) Male ( ) Female Locker#_____Combination_____
PARENT(S) OR GUARDIAN(S)

	MOTHER	FATHER
NAME		
ADDRESS		
HOME PHONE #		
CELL PHONE #		
PLACE OF WORK		
WORK PHONE #		

E-MAIL ADDRESS_____

EMERGENCY INFORMATION:
Persons designated below will be the only persons (other than parents) contacted by the school in the event of illness/accident/emergency. Relatives/Friends to be contacted if above individual cannot be reached:

Name_____ Name_____
Address_____ Address_____
_____ _____
Phone#_____ Phone #_____

If you have someone keeping your child after school, please indicate below:
Name_____ Phone #_____
Address_____

FAMILY
DOCTOR:_____ADDRESS_____PHONE#_____
FAMILY
DENTIST:_____ADDRESS_____PHONE#_____

IF AN EMERGENCY, WHICH HOSPITAL WOULD YOU PREFER_____

MECIDAL INSURANCE_____POLICY#_____GROUP#_____

I GIVE PERMISSION TO THE STAFF OF BERLIN BROTHERSVALLEY SCHOOL DISTRICT TO TRANSPORT OR TO MAKE ARRANGEMENTS FOR THE TRANSPORTATION OF MY CHILD TO EMERGENCY MEDICAL CARE.

_____
(PARENT'S SIGNATURE) (DATE)

BERLIN BROTHERSVALLEY SCHOOL DISTRICT
STUDENT HEALTH INFORMATION

NAME:_____ **DATE OF BIRTH:**_____ **( )MALE ( )FEMALE**

DOES THE STUDENT HAVE:

Allergies? YES___NO___ **PLEASE LIST:**_____
(FOOD, DRUG, SEASONAL/ENVIRONMENTAL) Has the allergy required any emergency action in the past?___yes___no
Comments:_____

Bee Sting Allergy? YES___NO___ **DESCRIBE REACTION:**_____
If stung, does student have difficulty breathing? ___yes___no
List emergency medication:_____

Asthma? YES___NO___ **TRIGGERED BY:**_____
TREATMENT:_____

Diabetes? YES___NO___ **DATE DIAGNOSED:**_____
TREATMENT:_____

Epilepsy/Seizures? YES___NO___ **DESCRIBESEIZURE:**_____
DATE OF LAST SEIZURE:_____
TREATMENT:_____

Heart Condition? YES___NO___ **DESCRIBE:**_____
MEDICATION/RESTRICTIONS:_____

Bone, Muscle, or Joint Problem? YES___NO___ **DESCRIBE:**_____

Urinary Problems? YES___NO___ **DESCRIBE:**_____

Bedwetting? YES___NO___ **DESCRIBE:**_____

Bowel Problems? YES___NO___ **DESCRIBE:**_____

Can child use toilet without help? YES___NO___ **COMMENTS:**_____

Please check all that pertain to your child:

Eyes:__eye glasses __contacts __wears all of the time __for reading only __for distance only
__crossed eye(s) __lazy eye(s) other vision difficulty_____

Ears:__frequent ear infections Tubes:__right ear __left ear Hearing aid:__right ear __left ear
Other hearing difficulty_____

Other:__frequent nose bleed __frequent headaches __ADD/ADHD __phobias __bleeding disorder

Special Care Required:_____

Serious Past Illness, Surgery, or Injury:_____

Other information or concerns:_____

Does student take daily medication at home?___yes___no **Will medication be needed at school?**___yes___no
Name of medication(s) and reason(s) for taking:_____

_____

*****By law, if student requires prescription medication at school, a consent form must be completed by the prescribing doctor and parent/legal guardian. These forms are readily available from the school nurse.*****

SIGNATURE OF PARENT/LEGAL GUARDIAN_____**DATE**_____

(OVER)

NAME_____ GRADE_____

FAMILY MEMBERS

RELATIONSHIP	NAME	AGE	CHECK IF RESIDES WITH STUDENT	STATE OF HEALTH	OCCUPATION OR SCHOOL	GRADE REACHED IN SCHOOL
MOTHER						
FATHER						
BROTHERS						
SISTERS						
STEP-MOTHER						
STEP-FATHER						
STEP-BROTHERS						
STEP-SISTERS						
OTHERS						

How many people live with the child?_____

Have any members of the family died?_____

If there are any family problems (housing, employment, food, etc.) please list below:

_____

_____

_____

_____

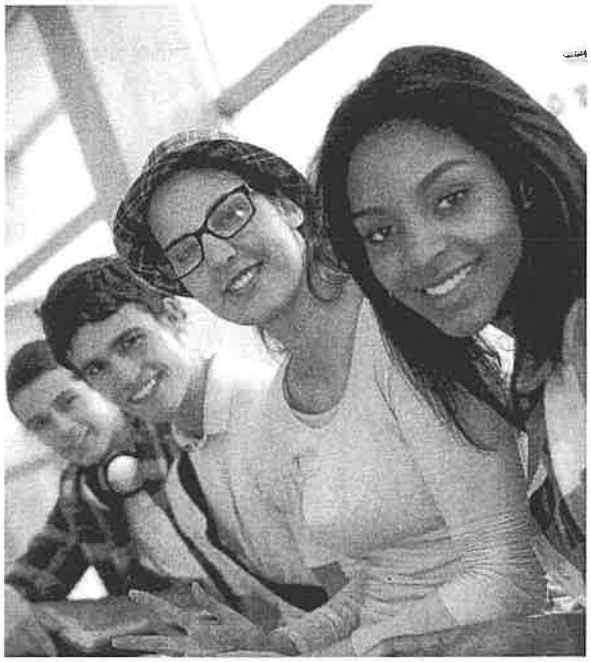
SIGNATURE OF PARENT/LEGAL GUARDIAN_____ DATE_____

SCHOOL VACCINATION REQUIREMENTS
FOR ATTENDANCE IN PENNSYLVANIA SCHOOLS

FOR ATTENDANCE IN ALL GRADES CHILDREN NEED THE FOLLOWING:

- 4 doses of tetanus, diphtheria, and acellular pertussis* (1 dose on or after the 4th birthday)
- 4 doses of polio (4th dose on or after 4th birthday and at least 6 months after previous dose given)**
- 2 doses of measles, mumps, rubella***
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox) or evidence of immunity

**Usually given as DTP or DTaP or if medically advisable, DT or Td*
*** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose*
****Usually given as MMR*



ON THE FIRST DAY OF SCHOOL, unless the child has a medical or religious/philosophical exemption, a child must have had at least one dose of the above vaccinations or risk exclusion.

- If a child does not have all the doses listed above, needs additional doses, and the next dose is medically appropriate, the child must receive that dose within the first five days of school or risk exclusion. If the next dose is not the final dose of the series, the child must also provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.

- If a child does not have all the doses listed above, needs additional doses, and the next dose is not medically appropriate, the child must provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.

- The medical plan must be followed or risk exclusion.

FOR ATTENDANCE IN 7TH GRADE:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) on the first day of 7th grade.
- 1 dose of meningococcal conjugate vaccine (MCV) on the first day of 7th grade.

ON THE FIRST DAY OF 7TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

FOR ATTENDANCE IN 12TH GRADE:

- 1 dose of MCV on the first day of 12th grade. If one dose was given at 16 years of age or older, that shall count as the twelfth grade dose.

ON THE FIRST DAY OF 12TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

The vaccines required for entrance, 7th grade and 12th grade continue to be required in each succeeding school year.

These requirements allow for the following exemptions: medical reason, religious belief, or philosophical/strong moral or ethical conviction. Even if your child is exempt from immunizations, he or she may be excluded from school during an outbreak of vaccine preventable disease.

Pennsylvania's school immunization requirements can be found in 28 Pa.CODE CH.23 (School Immunization). Contact your healthcare provider or call 1-877-PA-HEALTH for more information.

pennsylvania
DEPARTMENT OF HEALTH

BERLIN BROTHERSVALLEY SCHOOL DISTRICT

IMMUNIZATION RECORD

NAME_____ **DATE OF BIRTH**_____ **GRADE**_____

Diptheria & Tetanus (DTap, DTP, Td, DT)	1.	2.	3.	4.	5.
Tetanus, Diptheria, & 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, Ruebella (MMR)	1.	2.			
Varicella(Chickenpox) Diseases or Vaccine	1.	2.			
Meningococcal (MCV)*	1.	2.			
Hepatitis A	1.	2.			
Human Papillomavirus (HPV)	1.	2.	3.		
Other	1.	2.	3.	4.	5.
Other	1.	2.	3.	4.	5.
Other	1.	2.	3.	4.	5.
Other	1.	2.	3.	4.	5.
Other	1.	2.	3.	4.	5.

***Age appropriate dose of MCV and Tdap are required for entry into 7th grade.**

Name of Physician or Clinic where records can be verified:_____

***THIS FORM IS TO BE COMPLETED BY A PHYSICIAN/CLINIC- MUST BRING TO REGISTRATION OR HAVE A PRINTED COPY OF IMMUNIZATIONS FROM PHYSICIAN/CLINIC ATTACHED.**

BERLIN BROTHERSVALLEY SCHOOL DISTRICT

Dear Parent(s) or Guardian(s):

According to the Pennsylvania School Code all children upon original entry into school, *grade three*, and *grade seven* must have a dental examination. These grades were selected because they represent critical periods of dental development in a child's life.

I recommend these examinations be done by your child's family dentist as he can best evaluate your child's dental needs since he is familiar with your child's dental history and can make recommendations, corrections, provide the appropriate dental prophylaxis, and refer if necessary. The attached form is to be completed by the examining dentist and returned to me by October 1. The payment for this examination is the responsibility of the parent.

If you request that your child's dental examination be done in school, please sing consent on the form below and return to me. School dental examinations will be completed by our School Dentist, Dr. Peter C. Jacobson, D.M.D.

Please complete the form below and return directly to me as soon as possible. Thank you for your cooperation.

Sincerely,

R R Ritchey MSN, RN, CSN

Roxanna Ritchey, MSN, RN, CSN

Certified School Nurse

Students Name_____ Grade_____

____I prefer to have my child examined by his dentist, privately. I understand I will be responsible for the payment for this examination. **I will return the attached dental examination form signed by his/her dentist to the school nurse by October 1.**

____I prefer to have my child's dental examination done in school. I will be notified of any abnormal findings.

_____

Parent or Guardian Signature

_____

Date

H514.027 (08/2011-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
Last First Middle		☐ M ☐ F		

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 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
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____
Signature of Dental Examiner

_____
Print Name of Dental Examiner

_____
Address

BERLIN BROTHERSVALLEY SCHOOL DISTRICT

Dear Parent(s) or Guardian(s):

According to the Pennsylvania School Code all children upon original entry into school, grade *six* and grade *eleven* must have a physical examination. This is a legal requirement and not an option. These grades were selected because they represent critical periods of growth and development in a child's life.

I recommend these examinations be done by your child's family physician as he can best evaluate your child's health needs since he is familiar with your child's health history and can make necessary recommendations and/or referrals. The attached form is to be completed by the examining physician and **returned to me no later than October 1.** The payment for this examination is the responsibility of the parent.

Eleventh grade students who are receiving examinations for work permits, drivers' permits and athletic participation should take the attached form with them to their family physician for completion. This will prevent additional and unnecessary examinations.

If you request that your child's physical examination be done in school, please sign consent on the form below and return to me. **The physical examinations done in school may be done in conjunction with your child's athletic exam if he or she is an eleventh grade student.** Again this is to avoid additional and unnecessary examinations. School examinations are completed by an examiner from the practice of Family Health Care, Conemaugh Meyersdale Outpatient Center (Lindsay Menhorn, CRNP).

Please complete the form below and return to me as soon as possible. Thank you for your cooperation.

Sincerely,

RR Hy MSN RN CSN.

Roxanna Ritchey MSN, RN, CSN

Students Name:_____Grade_____

_____I prefer to have my child examined by his physician, privately. I understand I will be responsible for the payment of this examination. **I will return the attached physical examination form signed by his/her physician to the school nurse by October 1.**

_____I prefer to have my child examined in school. I will be notified of any abnormal findings.

_____ _____

Date Parent or Guardian Signature

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 NAME:

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: NORMAL	CHECK ONE: *ABNORMAL	CHECK ONE: 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:

BERLIN BROTHERSVALLEY SCHOOL DISTRICT

HEAD LICE "NO-NIT" POLICY

SECTION: PUPILS
TITLE: HEALTH EXAMINATIONS
SUBTITLE: HEAD LICE AND NITS
ADOPTED: MAY 5, 1988

Due to the rapid communicability of head lice and the chance of reinfestation, the Berlin Brothersvalley School District has adopted this head lice "No-Nit" policy.

Students having lice or nits shall be excluded from school until they are absolutely free of both lice and nits. Upon exclusion, information for treatment will be provided by the School Nurse. Students will not be permitted in school with nits in their hair even though parents claim they have been treated.

Upon return to school, it is recommended that a parent accompany the child for examination by the School Nurse for re-admission into school.

Students who are treated for this condition will have three (3) days of excused absence to remedy the problem, beginning with the day after the student is sent home from school. Any days missed after that date will be considered unexcused absences.

NOTICE AND INSTRUCTIONS FOR PARENTS REGARDING HEAD LICE

Head lice affect more people than all other childhood communicable diseases, not including the common cold. But like a cold, when children come in close contact with each other, it is easy to pass along head lice. Shared hats, clothing, brushes, pillows, and other personal articles are perfect vehicles to transfer lice from one person to another. It is important to act immediately to prevent their spread to other classmates and to other members of your family.

Head lice are small, only about 1/16" long. They are grayish-white with dark edges. While they cannot fly and do not jump, they do move quickly. That is why it is difficult to find them in a child's hair.

Diagnosis of head lice is generally made when lice eggs (called nits), which are fastened to the hair shaft, are clearly evident. Nits are teardrop in shape and also very small, only about 1/32" in size. They are "glued," to the hair and cannot be washed or brushed out like dandruff.

Clusters of nits may be found in any section of the hair, but they are more apt to be found behind the ears and at the nape of the neck.

Getting rid of heal lice is a matter of washing the hair with lice killing product and then very carefully removing all of the nits. A special nit-loosening rinse is also available which make the hob easier. **REMOVAL OF NITS IS IMIPORTANTO TO AVOID REINFESTATION**. Berlin Schools do have a "no-nit" policy, which excludes student from being in school with nits in their hair. After having had head lice, all students must first be checked by the School Nurse prior to reporting to homerooms on the morning they return to school.

WHEN YOUR CHILD COMES HOME WITH HEAD LICE....

1. Don't panic! Anyone can get head lice. It has nothing to do with cleanliness, nor does it reflect on you as a parent. The problem can be eliminated.
2. Examine your child's head to be sure you know what the nits look like. They are tiny grayish-white eggs attached to the hair, near the scalp, especially behind the ears and at the nape of the neck.
3. Check all other family members to see if they are infested. Any family member with evidence of heal lice must also be treated.
4. Use an effective lice treatment. Your pharmacist can recommend an effective pediculicide product. When used as directed, it will be effective in killing head lice.
5. Remove the nits (lice eggs). Because no pediculicide products kill all eggs, it is **VERY IMPORTANT** T to remove all traces of the nits to prevent reinfestation. A special comb for this task is usually provided with the lice treatment product; however, your fingernails are excellent tools for this purpose. Simply slide the nit out along the hair shaft until you have pulled it off.
6. Wash all clothes, bed linens and towels in hot water and dry on hot cycle for at least 20 minutes. Items that cannot be safely washed, such as stuffed animals, unwashable clothes, etc., should be dry cleaned or stored outside the home for a minimum of two weeks.
7. Clean combs and brushes in hot soapy water. Water should be at least 130 degrees F, and it is advisable to let the combs and brushes soak in the hot water for 10 minutes.
8. Vacuum everywhere to make sure your home is free of lice. Vacuum carpets, pillows, mattresses, upholstered furniture-anything that might hold lice. Do a thorough job and discard the vacuum bag promptly.

Head lice survive only on humans and do not affect family pets. To eliminate head lice and nits from your home, follow the directions above. Doing a thorough job will prevent their spread in the school community.

SECTION: PUPILS

TITLE: USE OF MEDICATIONS

ADOPTED: June 29, 1995

REVISED: September 2, 2010

Berlin Brothersvalley School District

210. Use of Medications

1. Purpose

The Berlin Brothersvalley School District recognizes that parents have the primary responsibility for the health of their children. Although the district strongly recommends that medication be given in the home, it realizes that the health of some children requires that they receive medication while in school.

Physicians should be made aware of the problems associated with giving medications in the school setting and arrange for medication to be administered before and/or after school hours whenever possible.
When medication must be administered during school hours, the following procedure shall be followed in order to ensure student safety, to prevent mistakes, illegal acts or possible liability for the school district and its employees.

2. Procedure

Administration of Prescription Medication During School Hours

Only a written request signed by the parent and a medication order from a licensed prescriber containing the following will be accepted:

a. Date

b. Child's name

c. Diagnosis

d. Name of the medication

e. Route and dosage of the medication

f. Required administration time and frequency

g. Termination date for administration of the medication

h. Listing of all other medication being taken at present, both prescription and non-prescription

i. Any restrictions on school activities

j. Any particular condition or circumstances relating to this patient that should cause the school nurse not to administer the medication

k. Any particular side effects relating to this patient that the school nurse and any school personnel should make special effort to inquire about or observe

l. Licensed prescriber phone number

m. Licensed prescriber signature

The initial dosage of the medication shall have been administered either at the student's home, the physician's office, or the hospital except in the case of an emergency. In the case of an emergency, the initial dosage may be administered in school. "Initial dosage" refers to the first dosage administered from the prescription.

All medication orders must be renewed each school year.
Prior to the administration of any medication, the school nurse must verify that they are administering the right medication to the right student, in the right dosage and the right route at the right time.
Any medication that is distributed during school hours must be documented in the student's School Health Record. The following information must be included in this record:

a. Student name

b. Date and time medication was given

c. Name of medication

d. Dosage

e. Route and site of administration

f. Signature of licensed person administering/observing medication being taken

g. Where necessary in the opinion of the school nurse, results should be charted in order to document whether appropriate results are being obtained.

Delivery of Medication

Any medication to be given during school hours must be delivered directly **to the school nurse by the student's parent(s) or guardian(s). The medication must be brought to school in the original pharmaceutically dispensed and properly labeled container and may not at any point be placed in any other container for storage.**

The primary care provider should issue a prescription to the pharmacist instructing the pharmacist to place all medications that should be taken during the school day in a separate and properly labeled prescription container from the portion of the medication that will be administered outside of the school day.

Upon receipt, the school nurse will document the quantity of medication received, the date of receipt, and the time of receipt. This documentation shall be signed by both the school nurse and the parent or guardian delivering the medication. Under no circumstances shall the school nurse accept medications in plastic bags or any containers other than the original pharmacy container.

Prior to the administration of any medication, the school nurse will ensure that the student who is to receive the medication has been positively identified so that no medication is administered to the wrong student.

Consent forms for prescription medication should be signed and accompany the medication. **These consent forms must contain the parent or guardian's printed name, signature, and an emergency contact phone number; a statement approving the school nurse, registered nurse or licensed practical nurse to administer medications; and a list of all other medications that the student is currently taking. These forms must also be accompanied by the Medication Order as described earlier in this policy.**

Personnel Responsible for Administration of Medication

The school nurse will be responsible for administering or supervising the

administration of all medication. A prescription drug log will be kept on any student receiving prescription medication during school hours.

Supply of Medication

For all illnesses, whether short-term, long-term, or a daily medication, a supply of **no more than** two-weeks **should be brought to the district. A written re-authorization will be required from the parent and the prescribing physician on the first day of each school term for all long-term or daily dosage medications.**

For short term illnesses, after the expiration of the medication order, a new written request and medication order will be required before any medication will be administered.

Storage of Medication

Prescription medication will be kept in a locked cupboard in the nurse's office in the elementary school's health room. **All prescription medications will be stored in their original pharmacy container. Access to medications is limited to the school nurse and any other licensed professionals, except in the case of a life-threatening emergency.**

Students' in grades 4-12 will be responsible for reporting to the health room at the time the medication is to be given. In grades K-3, individualized plans will be made for the administration of medication by the school nurse.

Non-Prescription Medication

Non-prescription medication for students in grades K-12 that must be given during school hours must be delivered to the school nurse in its original properly-labeled container and accompanied by a written request signed by the parent or guardian and a medication order signed by the licensed prescriber to allow administration to students in grades K-12 by the school nurse. Without a proper written request and a written order signed by the licensed prescriber the medication will not be given during school hours. Medications that fall under the school district's list of standing orders are exempt from this requirement.
Information on the request shall include:

a. Date

b. Child's name

c. Reason for giving the medication

d. Name of medication

e. Dosage

f. Time to be administered

g. Termination date for administering the medication

h. Other medication being taken at the present time, both prescription and non-prescription

i. School activity restrictions

Other Guidelines For All Medications

The parent of the child must inform the school nurse of any change in the child's health or change in medication varying from the original written instructions.

In the event the following specific requirements are not met, the School District retains the discretion to reject requests for administering medications:

a. Requirement for written authorization by legal parent

b. Requirement for written orders by prescribing physician

c. Requirement that medication be delivered to the school in its original pharmaceutically labeled container

d. Requirement for written indication that initial dosage has been administered either at home, the physician's office, or the hospital—except in life-threatening emergency situations

e. For long-term medication, written re-authorization by parent and prescribing physician shall be received in school on the first day of each school term.

Emergency Medications

Under Pennsylvania law, any officer or employee of a school who in good faith believes that a student needs emergency care, first aid or rescue and who provides such emergency care, first aid or rescue shall be immune from civil liability as a result of any acts or omissions by

	the officer or employee, except any acts or omissions intentionally designed to seriously harm or any grossly negligent acts or omissions which result in serious bodily harm. **Students may self-administer emergency medication in school when they have the authorization of a licensed prescriber, their parent or guardian, and the district. Prior to permitting a student to self-administer, the school nurse will perform a baseline assessment of the student's health status; ensure that the student is competent in self-care through the demonstration of the skills necessary for proper administration of the medication and responsible behavior regarding same; and engage in periodic and ongoing assessment of the student's self-management skills.** **The student will be required to notify the school nurse immediately following each self-administration.** **The medication will be confiscated and the student will lose self-administration privileges if this policy is abused or ignored.** **Policy Distribution** A copy of this policy will be provided to parents upon request.

BERLIN BROTHERSVALLEY SCHOOL DISTRICT

MEDICATION CONSENT FORM (REVISED 09/02/10)

If at all possible, please arrange for medication to be given before and/or after school hours. However, if medication must be administered during school hours, please complete this form.

I hereby request that the Berlin Brothersvalley School District, through its appropriate licensed personnel, administer to my child medications as described below. Currently, this child is taking the following other medication: _____

Has the child been given the initial dosage of medication outside of school? _____

_____ _____

(Date) (Parent or Legal Guardian's Signature)

.....

Consistent with the above request by the parent of the below-identified child, I hereby request that the Berlin Brothersvalley School District allow its appropriate licensed personnel to administer a medication as follows:

A. Child's Name: _____ Grade: _____ Date of Birth _____
B. Diagnosis: _____
C. Name of the Medication: _____
D. Dosage: _____
E. Time to be Administered: _____
F. Termination date of Administration: _____
G. Other medication currently being taken: _____
H. School Activity Restrictions: _____
I. Any particular condition circumstance relating to this patient that should cause school personnel not to administer the medication: _____
J. Any particular side effect relating to this patient that school personnel should make special effect to inquire about or observe: _____
K. May the student self administer the above medication? YES or NO

_____ _____ _____

(Date) (Licensed Prescriber's Signature) (Phone)

CHILDREN'S VISION SCREENING

A service of:

Somerset County Blind Association
A Division of Blind & Vision Rehabilitation Services of Pittsburgh

Dear Parent/Guardian:

One in twenty children has an undetected vision problem. The early detection and treatment of vision deficiencies are fundamental to future classroom learning and success.

To ensure that children 1 to 6 years of age are seeing as well as they should, **Blind & Vision Rehabilitation Services** offers a free *Children's Vision Screening* program for the children of Somerset County.

Children are screened for *visual acuity, muscle balance, and color discrimination* using techniques approved by the American Academy of Pediatrics. Our photo-screening machine is 99% accurate, extremely efficient, and a very kid-friendly experience.

If you have questions regarding the program, please contact me at the Somerset County Blind Association at 814-381-4361.

Sincerely,

Becky Fidler

Coordinator of Children's Vision Screening

A REMINDER: This is a screening. It is not a complete eye exam. BVRS recommends that every child have a complete vision exam by an eye care professional before entering kindergarten.

Children's Vision Screening is free, but your donations help us reach as many school and children as we can!

Your tax-deductible donation to **Blind & Vision Rehabilitation Services** will allow this valuable prevention of blindness program to continue. Donations can be attached to this permission slip.

THANK YOU IN ADVANCE FOR YOUR SUPPORT!

Please return to teacher by _____

PERMISSION FOR VISION SCREENING

School _____

Child's Name _____

Age: _____ Birth date: ____/____/____

Sex: M ____ or F ____ Ethnicity: _____

Parent/Guardian Name _____

Address _____

City & Zip Code _____

Phone (H) _____ (C) _____

E-Mail _____

How would you prefer to be contacted for follow-ups? **Phone or E-mail**

Has child ever been under the care of an eye specialist? Y N

Is child currently under the care of an eye specialist? Y N

Does child wear glasses? Y N

GLASSES MUST BE WORN ON THE DAY OF THE SCREENING.

Parent/Guardian Signature _____ Date _____

My signature grants permission for the vision screening and for the release of results to the facility's professional staff. You will be notified of the screening results in the form of a Parent Letter the day of the screening.

FOR STAFF USE ONLY:

Pass_____ **Refer**_____

Color _____

Unable: Unwilling _____ **Undetectable**_____

Notes: