Consent for School Physical

Students in Kindergarten or 1st grade, 6th grade and 11th grade are required to have physical examinations.

This can be done by your private physician or by the school medical examiner. You are encouraged to have this done by your family physician since he/she is familiar with your child's past medical history.

The school medical exam will include examination of:

- Ears, nose, mouth and throat
- Neck
- Chest- heart and lungs
- Abdomen
- Musculo/skeletal
- Neurologic

You will be informed in writing or by phone call of any abnormality.

Please sign and return this form to the school nurse. If you refuse to have the school medical examiner complete this examination, you are responsible to complete a private examination to comply with the Pennsylvania mandate.

Please call the school nurse with any questions.

Name **Grade**

☐ I give permission for my child to be examined by the Lincoln Leadership Academy Charter School medical examiner.

☐ I will have this examine done by my doctor, and return the private examination form to the school nurse.

Signature of Parent/Guardian **Date**

El consentimiento para la Escuela Física

Los estudiantes de Kindergarten, primer, sexto y undécimo grados están obligados a someterse a exámenes físicos.

Esto se puede hacer por su médico privado o por el examinador de la escuela de medicina. Se le recomienda que esto se haga por su médico de cabecera ya que él / ella está familiarizado con los antecedentes médicos de su hijo.

El examen de la escuela de medicina incluirá un examen de:

- Las orejas, la nariz, la boca y la garganta
- Cuello
- Cofre de corazón y pulmones
- Abdomen
- Trastornos músculo / esquelético
- Neurológica

Se le informará por escrito o mediante una llamada de teléfono de cualquier anomalía.
Por favor firme y devuelva este formulario a la enfermera de la escuela. Si se niega a tener la facultad de medicina forense completar este examen, usted es responsable de completar un examen privado para cumplir con el mandato de Pensilvania.

Por favor llame a la enfermera de la escuela con cualquier pregunta.

Nombre/ Grado ________________________________

☐ Doy permiso para que mi hijo sea examinado por el Lincoln Leadership Academy Charter School médico forense.

☐ Voy a tener este hecho examinar por el médico, y devolver el formulario de examen privado a la enfermera de la escuela.

Firma del Padre / Guardián __________________ Fecha __________

Lincoln Leadership Academy Charter School
Allentown, Pennsylvania

Pennsylvania State Required Physical Exams

The School Health Law of Pennsylvania requires a children to have a physical examination upon original entry into school (Kindergarten or First Grade), and in the sixth and eleventh grades. You are encouraged to have this examination done by your Family Physician at your expense. The PRIVATE PHYSICIAN'S REPORT FORM is attached. This may be done at the same time your child has a Physical Examination for summer camp, routine yearly check up, daycare, working papers, or driver's license. Physicals done within one year are acceptable.

If you do not have health insurance call toll-free 1-877-543-7669 or go to the Office of Public Assistance @ 7th and Walnut Sts. If additional help is needed, please call your school nurse.

Immunizations are available at the Allentown Health Bureau at 6 and Chew Sts. Call 610-437-7754 for an appointment.
PHYSICALS ARE GIVEN BY:

1. Your Family Physician
2. St. Luke's Allentown Campus
   Pediatric Clinic
   1648 Hamilton Street
   Call (610) 770-8380 for an appL
3. Sacred Heart Hospital Pediatric Clinic
   421 Chew Street
   Call (610) 776-4767 for an appt.
4. Lehigh Valley Hospital Center Pediatric Clinic
   17th and Chew Streets
   Call (610)969-4300 for an appL
5. The Caring Place Family Health Program
   931 Hamilton St. 4th Floor
   Call (610)433-4680 for an appt
   No Insurance Only
6. Case Guadalupe
   143 Linden St Call (610) 437-2703
   for an Appt

IF YOU RESIDE IN THE FOLLOWING TERRITORY
Dodd Elementary School, 1944 S Church St. Harrison Morton Middle School, 137 N 2nd St. Jefferson Elementary School, 750 SL John St.. Mosser Elementary School, 129 S. Dauphin SL Roosevelt Elementary School, 210 W. Susquehanna St Sheridan Elementary School, 521 N. 2nd St. South Mountain Middle School, 709 W. Einmaus Ave. **Please call the Sacred Heart Health Centers for an Appt** (484)765-5976

Central School, 829 N. Turner St
Please call Lehigh Valley Hospital for an Appt (484)765-5943

Raub Middle School, 192 St. Cloud St.
Please call for St Lukes for appt (484)765-5302

THERE WILL BE A SLIDING SCALE FEE AT CLINICS FOR ALL EXCEPT THOSE WITH MEDICAL ASSISTANCE CARDS

Please return the form below to the school nurse within 3 days

Name of student________________ Homeroom________ Grade________

Name of Dr/Clinic________________________

Name of Insurance________________________

Appt Date and time________________________

Lincoln Leadership Academy Charter School

EL ESTADO DE PENNSYLVANIA REQUIERE EXAMENES

La Ley de Salud Escolar de Pennsylvania requiere que todos los ninos reciban un examen fisico cuando ingresan a la escuela (en Jardin de Infantes o Primer Grado), y en los grados seis y once. Le animamos que hagan este examen por medio de su Medico familiar. Hemos incluido el formulario "REPORTE DE SU MEDICO DE FAMILIA." Esto se puede llevar a cabo cuando su hijo/hija le ban dado un examen fisico para el campamento de verano, tiene su revision anua con el medico, va a obtener un permiso di trabajo o cuando pide la licencia de conducir. Los examenes fisicos tienen validez de un ano.

Si usted no tiene seguro medico puede llamar gratis al 1-877-543-7669 o puede ir a la Oficina de Servicio Publico que queda en la esquina de la calle 7 y la calle Walnut. Llame por favor, a su enfermera escolar si necesita mas ayuda.

Las vacunas estan disponibles en el Centra de Salud de Allentown que queda en la esquina de la calle 6 y la calle Chew. Para hacer su cita llame al 610-437-7754.

EXAMENES FISICOS SON DADOS POR:

1. Su medico familiar
2. St. Luke's
   Allentown Campus
   1501 Lehigh Street
   Llame (610) 770-8380 para hacer una cita
3. Sacred Heart Hospital Pediatric Clinic
   421 Chew Street
   Llame (610) 776-4767 para hacer una cita
4. Lehigh Valley Hospital Center Pediatric Clinic
   17th and Chew Streets
   Llame (610)969-4300 para hacer una cita
5. The Caring Place Family Health Program
   931 Hamilton St. 4th Floor Llame (610)433-4680 para hacer una cita Solo si no tiene seguro
6. Casa Guadalupe
   143 Linden St. Llame (610) 437-2703 para hacer una cita

SI VIVE EN EL SIGUIENTE TERRITORIO Dodd Elementary School, 1944 Church St. Harrison Morton Elementary School, 137 N. 2nd St. Jefferson Elementary School, 750 St. John St Mosser Elementary School, 129 S. Dauphin St. Roosevelt Elementary School, 210 W.Susquehanna St. Sheridan Elementary School, 521 N. 2nd St. South Mountain Elementary, 709 W. Emmaus Ave

Por favor llame los Centres de Salud del Sagrado Corazon para hacer una cita. (484)765-5976

Central School, 829 N. Turner St.
Por favor llame Lehigh Valley Hospital para hacer una cita.
(484)765-4818

Raub Middle School, 192 St. Cloud St.
Por favor llame St. Lukes para hacer una cita. (484)765-5302

HABRA UNA ESCALA DE PAGO EN LAS CLINICAS PARA TODOS AQUELLOS QUE NO TENGAN TARJETA MEDICA DE ASISTENCIA

Por favor devuelva el siguiente formulario a la enfermera escolar dentro de los siguientes tres dias.

Nombre del estudiante: ______________________ Grade: ________ Salon: ________

Nombre del Medico/Clinica: ______________________

Nombre del Seguro Medico: ______________________

Dia y hora de la cita: ______________________

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 ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ 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 ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ 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 __________

Adapted in part from the *Pre-participation Physical Evaluation History Form*; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

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	*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 ☐

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)

Lincoln Leadership Academy Charter School
Allentown, Pennsylvania

IMMUNIZATION REQUIREMENTS FOR KINDERGARTEN AND ORIGINAL ENTRY ENROLLMENTS

The Pennsylvania Department of Health requires that all children at any grade, K through 12, show written proof of the following immunizations before they can attend school in the Commonwealth. The Allentown School District additionally requires the following immunizations for admission into all district-operated preschool programs.

Diptheria/Tetanus Vaccine -1 dose with plan for completion of the required 2 remaining doses within 8 months of entrance to school (to be reviewed every 60 days).*
4th Diptheria/Tetanus (DT) Vaccine- administered on or after age four.

Polio Vaccine - 1 dose with plan for completion of the required 2 remaining doses within 8 months of entrance to school (to be reviewed every 60 days).*

Measles Vaccine — 1 dose of live vaccine, the 1st dose administered at 12 months of age or older (or measles immunity proved by blood test) with plan for the completion of the one remaining dose within 8 months. This second dose of measles is recommended as MMR2.

German Measles (Rubella) Vaccine - 1 dose of live vaccine administered at 12 months of age or older, or Rubella immunity proved by blood test.

Mumps Vaccine - 1 dose of live vaccine administered at 12 months of age or older or a signed physician's statement to verify a diagnosis of Mumps disease.

Hepatitis B Vaccine - 1 dose with plan for completion of required 2 remaining doses within 8 months of entrance to school (to be reviewed every 60 days).*

Chickenpox (Varicella) Vaccine - Required with one of the following:

- 1 dose administered at 12 months of age or older (up to 12 years old).
- For 13 years of age or older, 1 dose with plan for completion of 1 remaining dose administered at least 1 month (minimum 28 days) after 1 dose (to be reviewed every 60 days).*
- A history of chickenpox immunity proved by laboratory testing or a written statement of history of disease from the parent, guardian, or physician.

***If the requirements are not met, the school administrator shall undertake exclusion procedures.**
Exceptions to immunizations: Medical Contraindications (letter from Physician) or Religious Convictions (letter from parent).

Lincoln Leadership Academy Charter School

Allentown, Pennsylvania

REQUISITOS DE INMUNIZACION Y MATRICULA ORIGINAL DE ADMISION PARA KINDERGARTEN

El Departamento de Salud de Pensilvania requiere que todos los estudiantes en cualquier grade, K a 12, presenten evidencia escrita de las siguientes inmunizaciones antes de asistir a una escuela del estado. El Distrito Escolar de Allentown requiere en adicion las siguientes inmunizaciones para admitir estudiantes en todos los programas preescolares operados por el distrito.

Vacuna de la Difteria/Tetano - Una dosis con el plan de completar las dos dosis requeridas dentro de los ocho meses de haber entrado a la escuela (documentacion a ser revisada cada 60 dias).*
Vacuna 4ta. Difteria/Tetano (DT) - Administrada a los/o despues de los cuatro (4) afios.

Vacuna del Polio - Una dosis con el plan de completar las dos dosis requeridas dentro de los ocho meses de haber entrado a la escuela (documentacion a ser revisada cada 60 dias).*

Vacuna del Sarampion - Una dosis de vacuna, la primera dosis administrada a los 12 meses de edad o mayor (o inmunidad al sarampion probado por examen de sangre) con un plan de completar la dosis restante en los proxirr>~s 8 meses. Se recomienda que esta segunda dosis de sarampion sea MMR2.

Vacuna del Sarampion Alemdn (Rubeola) - Una dosis administrada a los 12 meses de edad o mayor, o inmunidad a la Rubeola probado por examen de sangre.

Vacuna de la Paper a - Una dosis administrada a la edad de 12 meses de edad o mayor, o una nota del medico firmada para verificar un diagnostico de enfermedad de Papera.

Vacuna de Hepatitis B - Una dosis con el plan de completar las dos dosis restantes requeridas dentro de los primeros ocho meses de haber entrado a la escuela (documentacion a ser revisada cada 60 dias).*

Vacuna de la Varicela - Una de las siguientes es requerida:

- Una dosis administrada a los 12 meses de edad o mayor (hasta los 12 anos de edad).
- Para los estudiantes de 13 anos o mayores, una dosis con el plan de completar la dosis restante la cual debe ser administrada al menos un mes (minimo 28 dias) despues de la primera dosis (documentacion a ser revisada cada 60 dias).*
- Un historial de inmunidad a la varicela evidenciado por un examen de laboratorio o evidencia por escrito sobre el historial de la enfermedad provista por un padre, guardian/tutor o medico.

De los requisites no ser cumplidos, el administrador escolar debera llevar a cabo los procedimientos de exclusion. Excepciones a las inmunizaciones: Contraindicaciones medicas (carta de un medico) o convicciones eligiosas (carta de un padre, guardian/tutor).

Dear Parents:

It is very important that you do not send medications to school for your child unless it is absolutely necessary.

If your child has recovered from an illness, but is still on medication to be given four times a day, it may be possible for him/her to take the proper dosage spaced before school, after school, at evening meal time at bed time. Discuss the possibility with your physician.

If your child has a chronic medical problem and must take medication during school hours in order to keep his/her medical condition under control, please call the school nurse. She will explain to you the School's Medication Policy and give you the proper forms to complete so that your child may receive the required medication in school.

Estimados Padres:

Es de suma importancia que usted no mande medicinas para su hijo(a) a la escuela a menos que sea absolutamente necesario.

Si su hijo(a) esta recuperandose de una enfermedad, pero todavia esta tomando medicamento cuatro veces al dia, puede ser possible que se beba la dosis apropiada antes de comenzar sus clases. despues de sus clases, durante la cena y al acostarse. Favor de hablar sobre esta posibilidad con su doctor.

Si su liijo(a) tiene una enfermedad cronica, la cual require que tome medicinas durante el dia escolar para poder controlar su condicion. por favor comuniquese con la enfenmera. Ella le explicara las reglas escolares acerca de los medicamentos y le **proporcionara** los formularios apropiados para que los llene y asi su hijo(a) podra tomar la medicina durante el dia escolar.

La enfenmera escolar estara dispuesta a hablar con usted y darle respuestas a las preguntas especificas que usted tenga sobre este tema.

Lincoln Leadership Academy Charter School
Allentown, Pennsylvania

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

FOR THE PHYSICIAN:

______________________________ must receive medication prescribed by me for the following
Student's Name

condition:

This medication must be given during school hours in order to maintain sufficient health and participation in the school program.

Medication______________________________

Prescribed daily dosage______________________________

Time and dosage to be given in school______________________________

Duration period______________________________

Possible side effects______________________________

Permission to carry inhaler during school hours______________________________

Signature of Physician______________________________

Print Name of Physician: ______________________ Phone Number: ____________ Date: ________

FOR THE PARENT OR GUARDIAN:

I give permission for the Lincoln Leadership Academy Charter School nurse and/or their designee to administer the above medication to my son/daughter ______________________ as prescribed by the physician.

I agree to deliver the medication to the school in a labeled prescription bottle. The label shall contain the name of the medication, the prescribed dosage, the physician's name and the pharmacy.

I further agree to deliver a new supply of medication to the school, as needed.

I authorize the Allentown School District to exchange health-related information with the above-named Physician.

I understand that a new medication authorization form must be completed by the parent and physician if the dosage is changed at any time.

Signature of Parent(s) or Guardian(s): ______________________________

Telephone Number: ______________________________

Notice for Family Dental Report

Students in Kindergarten or 1st grade, 3rd grade and 7th grade are required to have dental examinations. This should be done by your family dentist since he/she is familiar with your child's past dental history.

We have not received a Dental Report. If your child has seen a dentist in the past year, you may have him/her sign the attached form and return it to school. If your child is scheduled to see the dentist please send a note to me as to when the appointment is scheduled. The form should be returned to the school nurse when it is completed by the dentist.

Starting in the fall we will be having the St. Luke's Dental Van visit the school on a regular basis. If you would like your child to be seen on the dental van you can obtain the paperwork from the school nurse or go to the Lincoln Leadership Academy Charter School website and print out the necessary forms.

Aviso para el Reporte Dental Familiar

Los estudiantes de Kindergarten o 1er grado grado y séptimo grado, tercero están obligados a someterse a exámenes dentales. Esto debe ser hecho por el dentista de la familia ya que él / ella está familiarizado con la historia pasada dental de su hijo.

No hemos recibido un informe Dental. Si su niño ha ido al dentista en el último año, es posible que él / ella firme el formulario adjunto y enviarlo a la escuela. Si su hijo está programado para ver al dentista por favor envíe una nota a mí en cuanto a cuándo está programada la cita. El formulario debe ser devuelto a la enfermera de la escuela cuando se completa con el dentista.

Comenzando en el otoño vamos a tener Dental Van de San Lucas visitar la escuela de forma regular. Si a usted le gustaría que su hijo puede ver en la furgoneta dental por favor obtenga los papeles de la enfermera o se puede buscarlos en el sitio de web de Lincoln Leadership Academy e imprimir los documentos necesarios.

H514.027

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 (Last, First, Middle)	AGE	SEX ☐ M ☐ F	GRADE	SECTION/ROOM

ADDRESS

No. and Street | City or Post Office | Borough or 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 ☐

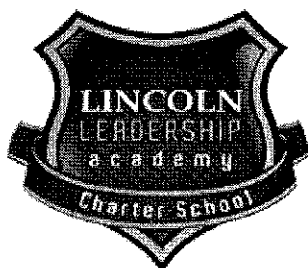
Treatment Completed Yes ☐ No ☐

Date of Dental Examination

Signature of Dental Examiner

Print Name of Dental Examiner

Address



Student Health Update

Date________________________ Return by________________________

To the Parent or Guardian of:____

In order for your child to receive the best nursing care at school, it is imperative that the requested information be completed by the child's parent/guardian and returned to the school nurse.

Your child's health record states that he/she has the following health condition(s):

Please respond to the present status of this condition. Check all that apply:

__________ Condition no longer exists

__________ Condition remains the same

__________ Condition is still present

__________ Special restrictions apply (explain below)

____

____

__________ Child is on medication

__________ Medication must be given at school (explain below)

____

Medication: Please list medications the child takes at home or school. If your child must take medication at school, the medical authorization form enclosed must be completed and signed by the **parent/guardian** and **doctor**.

If this form is not returned, it will be assumed your child no longer suffers from this health condition.

Actualización De Salud Para Estudiantes

Fecha:

Para los Padres o Encargados Legales:

Para que su hijo(a) reciba el mejor cuidado de las enfermeras de la escuela, es muy importante que la información que le estamos pidiendo sea completada por los padres o encargados legales del estudiante.

El registro de salud de su hijo(a) indica que su hijo(a) tiene la siguiente condición(es) de salud:

Por favor responda a la estado de esta condición. Marque todas las opciones que apliquen:

__________ La condición ya no existe

__________ La condición permanece igual

__________ La condición todavía está presente

__________Restrictiones especiales aplican (explique abajo)

____

____

__________Mi hijo(a) recibe medicamento

__________El medicamento debe ser administrado en la escuela (explique)

____

Medicina: Por favor escriba el nombre de las medicinas que su hijo toma en la casa o en la escuela. Si su hijo(a) debe tomar la medicina en la escuela, la forma de autorización medica adjunta debe ser completada por los padres o encargados legales y el doctor. esta en el sobre y devuélvala a la escuela.

Si la escuela no recibe esta forma, la escuela asumirá que su hijo(a) ya no sufre de una condición médica.

Firma del Padre/Encargado Legal ______________________ Fecha_________

Enfermera de la Escuela ____________________________ Fecha_________

Student Demographic Update

If any student information changes during the school year please be sure to fill this form out and return to the main office as soon as possible. Thank you for your cooperation.

Name____

Address____

Phone Number_______________________________________

Cell Phone Number___________________________________

Emergency Contact___________________________________

Emergency Contact Phone Number_____________________

Medical Condition Changes____________________________