Bethlehem Area School District
Shaping the future. One child at a time.

Education Center

1516 Sycamore Street, Bethlehem, PA 18017-6099
610-861-0500 • Fax 610-861-8107

Dear Parents/Guardians:

In order to protect school children from diseases of a serious nature, the Commonwealth of Pennsylvania requires that every child receive certain immunizations before being allowed to enter school. These immunizations are:

- Four (4) doses of Diphtheria and Tetanus toxoid (last one given after 4 years of age)
- Three (3) doses of Polio vaccine
- Two (2) doses of live attenuated Measles vaccine after 12 months of age (or serological evidence of immunity)
- Two (2) dose of live attenuated Mumps vaccine after 12 months of age or a physician/verified history of Mumps disease
- One (1) dose of Rubella vaccine after 12 months of age (or serological evidence of immunity)
- Three (3) doses of Hepatitis B
- Two (2) dose of Varicella (chicken pox) or history of disease

The law makes exceptions for those who cannot be immunized for medical reasons or because of religious beliefs. If there is any medical reason why your child should not be fully immunized, the "Medical Exemption" portion of the referral form STATEMENT OF EXEMPTION TO IMMUNIZED LAW should be completed by your family physician. Should you object to immunizations for religious reasons, the "Religious Exemption" portion should be completed by you as a parent or guardian. This form must be returned to your child's building principal.

If your child has not received all of the above-listed immunizations, we urge you to have them completed as soon as possible. Please be advised that your child cannot be admitted to school until you have complied with the above regulations.

Thank you for your cooperation in this matter.

Sincerely,

Joseph J. Roy, Ed.D.
Superintendent of Schools

JJR:acv
Att.
HS-106 (rev. 1/13)

Queridos Padres o Encargados:

Para proteger a los niños que asistan a las escuelas contra enfermedades serias, la ley del estado de Pennsylvania requiere que todo niño(a) debe ya haber tenido ciertas vacunas antes de ser admitido a la escuela. Estas vacunas son:

- Quatro (4) dósis de tos ferina de difteria y tétano (la última después de los 4 años de edad)
- Tres (3) dósis de la vacuna para Polio
- Dos (2) dósis de vacuna para Sarampion después de 12 meses de edad (o evidencia de inmunidad)
- Dos (2) dósis de vacuna para Falfayota (Papera) después de 12 meses de edad o verificación (a traves de un médico) que el niño(a) tenido la enfermedad
- Una (1) dósis de Rubella despues de 12 meses de edad (o evidencia de inmunidad)
- Tres (3) dósis de Hepatitis B
- Dos (2) dósis de Varicella (chicken pox) o verificación que el niño(a) tenido la enfermedad

Hay excepciones proveidas por la ley para personas que no pueden ser vacunadas por razones medicas o creencias religiosas. Si hay alguna razon médica por la cual su hijo/hija no debe ser vacunada, su médico debe completar la forma STATEMENT OF EXEMPTION TO IMMUNIZATION LAW, "Medical Exemption." Si usted se opone a las vacunas por razones religiosas, la forma "Religious Exemption" debe ser completada por el padre o encargado. Devuelva esta forma al principal del la escuela de su hijo/hija.

Si su hijo(a) no ha recibido todas las inmumizaciónes requeridas por la ley, les exhortamos que empieze a inmunizarlo enseguida. Queremos dejarle saber que su hijo(a) no será admitido a la escuela hasta que usted cumpla con estos requisitos.

Gracias por su cooperación en este asunto.

Sinceramente,

Joseph J. Roy, Ed.D.
Superintendente de Escuelas

Bethlehem Area School District

HEALTH HISTORY

Name _____ Date of Birth _____

M / F School _____ Grade/Homeroom _____

Mother's Name _____ Address _____

Father's Name _____ Address _____

Custody Arrangements _____

Last School Attended _____ County _____

Siblings:

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

Language Spoken at Home _____

Name of Doctor/Clinic _____ Dentist _____

Immunization Record -Please attach

Hospitalizations and Surgeries

Date	Diagnosis	Procedure	Resolution
_____	_____	_____	_____
_____	_____	_____	_____

Serious Injuries

Date	Type	Resolution
_____	_____	_____
_____	_____	_____

Chronic or Serious Medical Conditions

Date	Type	Resolution
_____	_____	_____
_____	_____	_____

Medications Taken Regularly

Name of Medication	Dose	Time	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

Medications _____

Insects _____

Foods _____

Other _____

Emotional Problems

Description _____

Resolution _____

_____ _____

Parent/Guardian Signature Date

Rev. 10/2012

El Distrito Escolar Bethlehem

HISTORIA MÉDICA

Nombre _____ Fecha de Nacimiento _____

M / F Escuela _____ Grado/Salón de Hogar _____

Nombre de la Madre _____ Dirección _____

Nombre del Padre _____ Dirección _____

Arreglos de Custodia _____

Last School Attended _____ County _____

Hermanos	Nombre	Edad
	_____	_____
	_____	_____
	_____	_____

Idioma Habado en Casa _____

Historial de Imunización Por favor attach

Hospitalizaciones y Cirugías

Fecha	Diagnosis	Procedimiento	Resolución
_____	_____	_____	_____
_____	_____	_____	_____

Heridas

Fecha	Tipo	Resolución
_____	_____	_____
_____	_____	_____

Condiciones Médica Crónicas o Serias

Fecha	Tipo	Resolución
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medicamento Tomado Regularmente

Nombre del Medicaments	Cantid	Frecuencia	Razón
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Alergias

Medicamentos _____

Insectos _____

Comidas _____

Otras _____

Problemas Emocionales

Decripción _____

Resolución _____

_____ _____

Firma de Padres/Engardos Fecha

Rev. 10/2012

Bethlehem Area School District
Shaping the future. One child at a time.

Education Center

1516 Sycamore Street, Bethlehem, PA 18017-6099
610-861-0500 • Fax 610-861-7577

Dear Parents/Guardians:

The School Health Law requires all children to have a medical and dental examination upon initial entry into school (kindergarten or first grade). Although these examinations may be carried out by the health services staff of the school district during your child's first year in school, there are advantages to having them completed by your family physician and family dentist before school opens. They know the past medical and dental history of your child and are best able to recommend any remedial care, which may be needed. Also examinations by your family physician and family dentist ensure continuity in medical and dental care, which cannot be secured through examinations provided in school.

The necessary forms for these examinations are attached to this letter. Please return the forms to your building principal before the close of this school year, or no later than the beginning of the new school year.

Should the forms not be signed and returned to the school, we will plan to have your child scheduled for the appropriate medical and dental examinations during the school year. You will be notified in advance of the date of your child's examinations and written consent is required to have the physical examination done in school.

Thank you for your cooperation in this important matter.

Sincerely,

Joseph J. Roy, Ed.D.
Superintendent of Schools

JJR:dlm
Att.
Rev. 08/10 (Letters/Health Folder)

Queridos Padres/Encargados:

La ley de salud escolar requiere que todo niño tenga un examen médico y dental cuando ingresa por primera vez a la escuela (kindergarten o primer grado). Aunque estos exámenes pueden ser hechos en la escuela durante el primer año que el niño(a) asista, es mejor que su doctor de familia y su dentista examinen a su niño(a) antes de empezar la escuela. Ellos estan familiarizados con los problemas de salud y dentales de su niño(a) y estan en la mejor disposición para hacer recomendaciones necesarias para corregir cualquier problema que exista. Además, hay mas posibilidades para la continuación del tratamiento, algo que no es garantizado cuando se provee este servicio en la escuela.

Le estamos enviando las formas necesarias para estos exámenes con esta carta. Favor devoler estas formas al principal de la escuela antes del final de este año escolar, o no más tardar alprincipio del nuevo añoescolar.

Si las formas no han sido devueltas a la escuela, haremos areglos para que su hijo(a) se le hagan los exámenes médicos y dentales durante el año escolar. Se le notificará de antemano la fecha del los exámenes de su niño(a).

Gracias por su cooperación en este asunto.

Atentamente,

Joseph J. Roy, Ed.D.
Superintendente de Escuelas

JJR:dlm
Att.

pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date _____

Date of birth _____ Age at time of exam _____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: *Has the student...*	YES	NO
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: *Has the student...*	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: *Has the student...*	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: *Has the student...*	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: *Has the student...*	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: *Has the student...*	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: *Has the student...*	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Asthma/lung problems ☐ Behavioral health issue ☐ Diabetes ☐ Inherited disease/syndrome ☐ Kidney problems ☐ Seizure disorder ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ Cardiomyopathy ☐ High blood pressure ☐ High cholesterol ☐ QT syndrome ☐ Marfan syndrome ☐ Ventricular tachycardia ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student _____ Date _____

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	CHECK ONE: 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)

H514.027 (08 2011)

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