Avonworth Primary Center
1310 Roosevelt Road
Pittsburgh PA 15237
412-366-7171
www.avonworth.k12.pa.us

March 3, 2022

Dear Kindergarten Parents and Guardians,

Welcome to Avonworth School District! We look forward to meeting your new kindergartener! Before the first day of school, there are a few things with which we need to make you familiar.

School Law of the Commonwealth of Pennsylvania requires physical and dental examinations for children upon entry into school. It is strongly recommended that your private physician and dentist perform these examinations as part of your child's yearly well-child visits. Attached are the forms to be filled out by the physician and dentist and returned to the school nurse **before the first day of school.** Exceptions may be made because of insurance coverage of physicals and birthdates of the child. Please discuss this with the nurse if your form cannot be completed by the first day of school. If you cannot afford these examinations, or need information on free health insurance coverage, please contact the school nurse.

Proof of immunization is required upon registration. Please review the immunization regulations provided and contact the school nurse if you have any questions. The nurse must have documentation of **ALL** required immunizations **BEFORE** the first day of school.

Your child will NOT be permitted to attend on the first day of school if immunizations are incomplete.

Proof of lead level testing is required upon registration.

Complete the health history form and turn this in at registration. Please contact the school nurse if your child has any health problems or special needs. (severe allergies, diabetes, seizures, asthma, etc.) We are looking forward to caring for your child. To provide the best possible care we need to work as a team. The more informed we are about your child the better care we can give them. Please do not hesitate to contact us with any questions or concerns.

Sincerely,

Mara Alterio, MSN, Certified School Nurse
malterio@avonworth.k12.pa.us

Phone: 412-366-7171 X1906 or X1812 **Fax Number** - 412-367-8307

Welcome to Avonworth Primary Center!

Health Information Checklist for Kindergarten Registration

All of the forms listed below can be printed by clicking the links below.

☐ Immunizations - due at registration

*Immunizations must be ***complete*** **BEFORE** the first day of school!!!

☐ Health History Form

**Completed by parent - due at registration

**Contact school nurse if your child has health issues
(severe allergy, asthma, seizures, etc.)

☐ Proof of Lead Testing

**Ask health care provider at physical exam appointment

☐ Physical Exam Form

**Completed and signed by health care provider and dated *after* July 1, 2020

☐ Dental Exam Form

**Completed and signed by dentist and dated *after* July 1, 2020

✳ Medication Procedure & Order Form

**Included for your information - notification of district medication procedures
DO NOT return unless your child will require medication during school hours

P dud#Dowhuk, Certified School Nurse

malterio@avonworth.k12.pa.us

412-366-7171 x 1906

School Vaccination

Children in ALL grades need the following **BEFORE** the first day of school:

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

- If all of the above are not complete and are medically appropriate they must be completed within the first five days of school.
- If the above will not be complete (for medical reasons) before the start of school a medical plan must be signed by a physician and be returned to the nurse. This plan must include the dates of when the missing immunizations will be given.
- The medical plan must be followed or risk exclusion.

AVONWORTH SCHOOL DISTRICT – STUDENT HEALTH HISTORY

Name:	Sex: **M / F**	Date of Birth:

I. **LIFE THREATENING CONDITIONS**		*****Emergency Action Plan required***** **(request from nurse)**	
YES	**NO**	**Does your child have:**	**Provide details for any YES answers**
		Severe allergies?	Specify allergens: Typical symptoms:
		Prescribed auto injecting epinephrine?	(must be provided to nurse)
		Severe Asthma (**regularly** takes asthma medication and/or hospitalized within the last 5 years for an asthmatic condition)	
		Diabetes	Type: Year of diagnosis:
		Seizure Disorder requiring emergency medication	Type: Year of diagnosis: Last Seizure: Medications:

*****Please note: Information on urgent health conditions may be shared with staff for safety purposes*****

II. SPECIAL HEALTH NEEDS			
YES	**NO**	**Does your child:**	**Provide details for any YES answers**
		Have a history of serious illness or surgeries?	
		Have any allergies not listed above?	
		Need to take any medication at school?	
		Follow a special diet?	
		Have any toileting issues?	
		Have any hearing loss?	
		Have any vision problems?	
		Have any other health needs of which the nurse should be aware?	

*****If your child requires medication in school, a written physician's order is required. No medication may be carried in school by a student; this includes "over-the-counter" medications. All medication must be delivered to the Nursing Office by a parent/guardian with the physician's original order and written parental permission. See attached Medication Procedures. Contact the School Nurse to discuss any health issues prior to the start of school. This information is necessary to assist the nurse in meeting your child's school health needs. All information is confidential but may be shared on a "need to know basis" to ensure your child's safety. Please contact the building nurse to discuss health issues prior to the start of school*****

Certified School Nurse: Mara Alterio,CSN malterio@avonworth.k12.pa.us 412-366-7171 x 1906 or x 1812

IV. HEALTH HISTORY **Provide details for any YES answers**

YES	NO	CONDITION	DETAILS
		Attention Deficit: ____ADD or ____ADHD Date Diagnosed:_____ Meds: **YES / NO**	
		Asthma / Reactive Airway ● Will your child require an inhaler or nebulizer at school? **YES / NO** ● **If YES-Fill out Action Plan** (request from nurse)	
		Autism / PDD	
		Arthritis / rheumatic Disease	
		Behavioral / emotional concerns	
		Birth / pregnancy complications	
		Bleeding Disorder	
		Bowel / digestive problem	
		Cancer, Type: _____ Date of diagnosis →	
		Cerebral Palsy	
		Cleft lip / palate	
		Cystic fibrosis	
		Dental problems	
		Growth problem	
		Heart problem specify →	
		Hernia	
		High blood pressure	
		Hospitalizations specify →	
		Immunodeficiency disease	
		Kidney / urinary problem	
		Lyme disease	
		Muscular disorder	
		Migraine headaches	
		Nutritional / weight problem / eating disorder specify →	
		Orthopedic problem (bone / joint)	
		Scoliosis / abnormal spinal curve - Date of diagnosis & last evaluation →	
		Sickle cell disease	
		Skin condition	
		Spina bifida	
		Tics or twitches	
		Other	

		My child has no special health needs or concerns	**Parent/Guardian initials:**

I understand & agree that if my child's health status changes during the school year, I will notify the Nursing Office. I have read & understood the above.

Parent/Guardian Signature_____ Date _____

Allegheny County Health Department

Lead Testing Record

To be filled out by parent or guardian

Student first and last name: _____

Birthdate: _____/_____/_____

Address: _____ City: _____

State: PA Zip code: _____-_____

Parent or guardian name: _____

To be filled out by health care provider

Date of most recent lead test: ____/_____/____

X _____

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

Date: ____/_____/____

If exemption is requested, please fill out back of form.

Other acceptable proof of testing: any written statement by the child's health care provider.

 Complete only if exemption is requested

Allegheny County Health Department

Statement of Exemption to Lead Testing Regulation

To be filled out by parent or guardian

Student first and last name: _____

Birthdate: ____/_____/____

Address: _____ City: _____

State: PA Zip code: _____-_____

Parent or guardian name: _____

Religious or Strong Moral/ Ethical Conviction Exemption

State your reason/s for requesting this exemption (required): _____

_____

_____

_____

Signed _____ Date ____/_____/____
(Parent or guardian)

To be filled out by health care provider

Medical Exemption

The physical condition of the above-named child is such that blood lead testing may be detrimental to his/her health.

Signed _____ Date ____/_____/____
(Physician)

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 ☐ 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_____

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**			***ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS**
	NORMAL	***ABNORMAL**	**DEFER**	
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:

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

AVONWORTH SCHOOL DISTRICT MEDICATION PROCEDURES

Medications brought to school that do not meet the following requirements will not be given.

****At A Glance***

- **ALL** medications require a medication administration form completed and signed by a guardian AND physician
- **ALL** medications **MUST** be in the original pharmacy container OR original packaging.
- Medication in plastic bags or other containers are **NOT** acceptable and will be disposed of immediately.
- Medications **MUST** be delivered directly to a nurse by an adult. Students are not permitted to carry medication in school or on the bus with the exception of some emergency medications with proper documentation.
- All medication orders must be renewed at the beginning of each academic year.
- Medications must be picked up by a parent or guardian by the last day of school.
- Medications will be disposed of if a parent does not pick up after expiration OR discontinuation OR at the end of the year for ongoing medications.
- Parent/guardian is responsible to inform the nurse of any changes in medications and to provide doctor's order.

Prescription Medications

- The parent/guardian & health care provider must complete the *Request for Medication Administration* form for EACH medication to be given at school. It is strongly recommended that medications be given at home whenever possible. All sections of the form must be filled out & signed.
- All prescription medication MUST be in the **original container with a pharmacy label.**

Non-Prescription (Over-the-Counter/OTC) Medications

- Nurses in Pennsylvania cannot administer **non-prescription** medications without a doctor's order.
- All medication orders for OTC medications must include the same information as prescriptions.
    - Name of student, prescriber & medication; Dosage; Route; Time
- All medications must be in the original labeled container.
- There is a standing order from our school physician to give Tylenol (acetaminophen) or Advil (ibuprofen) or TUMS. These will be given at the discretion of the School Nurse and **ONLY** with parent permission.
- The above medications will be given **ONLY** with written parental permission . No exceptions or courtesy calls will be made.
- **For primary/elementary students:** The above will only be given after communication with guardian.
- Any other **non-prescription medication will require a *Request for Medication Administration* form completed by a licensed prescriber and parent.**

Students are not permitted to carry ANY medications while at school. This includes prescriptions,

AVONWORTH SCHOOL DISTRICT MEDICATION PROCEDURES

Medications brought to school that do not meet the following requirements will not be given.

over-the-counter medications, vitamins, supplements.

Parents/guardians **MUST** deliver medications **directly** to the School Nurse and pick up any unused medications at the end of the school year or when a medication is discontinued. If medications are not picked up by a parent within a week of expiration/discontinuation OR by the end of the school year for daily/ ongoing medications they will be disposed of appropriately. Strict adherence to this policy is necessary for the safety of all students, and to protect your child and yourself from responsibility should these medications fall into the hands of another student on the bus or school property.

Emergency or Chronic Disease Medications

- This includes all medications used to treat severe allergic reactions, anaphylaxis, asthma, diabetes, seizures, etc.
- These medications must be kept in the health office at all times. A *Request for Medication Administration* form and information about the specific student must be provided to the nurse. Students with asthma, severe allergies, seizures, diabetes should have an Action Plan on file. (See school nurse or website). It is the responsibility of the parents/guardians to deliver these medications to the nurse on or before the first day of school. They must be available in the Health Office for emergency use.
- In accordance with Pennsylvania state law, students with severe or unstable illnesses may carry certain medications (epinephrine autoinjectors, inhalers, diabetes medications) at school or on the bus. If a student is unable to self-administer a medication, parents may opt to make special arrangements with the transportation company. Students must demonstrate responsible behavior in using the medication. Failure to do this will result in withdrawal of permission to carry and use medication.
- Students carrying and administering their own asthma inhaler or auto injecting epinephrine must have a completed and signed waiver on file. For students in grades 7-12, in lieu of licensed prescriber statement, the nurse may make a determination that the student is competent of self administration.
- It is the responsibility of the parents of students with asthma, severe allergies, or other chronic conditions possibly requiring medication/treatments outside of school hours to make arrangements with the supervisors of those activities.
- Please note that to ensure the safety of your child, basic information regarding life-threatening and emergency conditions may be shared with staff interacting with your child. If you wish for this information to be withheld you must let the building nurse know in writing.

Field Trips

- Administration of non-emergency/daily medications on a field trip will be addressed with parent/ guardian on an individual basis. Be sure this section of the *Request for Medication Administration* form is completed by the prescriber.

AVONWORTH SCHOOL DISTRICT
Request for Medication Administration in School

To be completed by licensed prescriber: **Date: _____**

Student's Name:	**Grade/Homeroom:**

Medication Name	**#1**	**#2**
Dosage & Route		
Time of Administration		
Length of Administration	**Start Date** _____ **Stop Date**	**Start Date** _____ **Stop Date**
Reason for Medication		
Administration Instructions		
Side Effects		
Field Trips	**Please check one of the following options when a parent/guardian or parent/guardian designee (non-staff) is unable to attend a field trip:** **_____ Yes, the prescribed dose can be withheld on the day of the field trip.** **_____ Yes, the time can be adjusted with parent to be administered upon return to school.** **_____ No, this medication must be given to the child at the prescribed time.** **Explain:_____**	
Competency for Self Administration (inhaler or auto-inject epinephrine)	**I, _____ (licensed prescriber's printed name), certify that this student has a potentially life threatening illness and requires an inhaler or auto injecting epinephrine. This student is competent and has been instructed in the proper method of self administration of said medication. This student may therefore carry and self-administer his/her inhaler or auto injecting epinephrine.**	
Signature of Licensed Prescriber	_____ Phone: _____ **(Not valid without licensed prescriber signature)**	

To be completed by Parent/Guardian:

I give permission for my child to receive the above noted medication at school. I waive and release the District and any District employee from any and all liability or responsibility for the administration of the medication or benefits or consequences of the medication and acknowledge that the District bears no responsibility for ensuring that the medication is taken. I also give my permission for the school nurse to contact the licensed prescriber, as necessary, regarding the medication.

Parent/Guardian Signature: _____ **Date:** _____
(Not valid without signature)

If there is a two hour delay of opening school:

_____ Yes, administer my child's medication as prescribed

_____ No, I will contact you if the time is to be adjusted