LAUREL SCHOOL DISTRICT

"Excellence through discipline, strength through unity!"

2497 Harlansburg Rd. New Castle, PA 16101 : Phone (724) 658-8940 *Fax: 724-598-9947*
laurelspartans.com

MANDATED PHYSICAL EXAMINATION

Dear Parent/Guardian:

I. According to Article XIV of the Public School Code and related regulations, students entering **kindergarten, sixth grade, and eleventh grade** must undergo a physical examination (28 Pa. Code 23.1-23.87, Health Services).

II. The State of Pennsylvania accepts physical examinations completed any time during the school year *preceding* their kindergarten, sixth, or eleventh-grade enrollment.

A. If your child has had a physical examination during this time, please ask your child's pediatrician to fax or send you proof of the examination. Once you receive it, kindly return it to the school nurse.

III. If your child is due for or has a scheduled physical examination with their pediatrician during their **kindergarten, sixth, or eleventh-grade year**, please ensure that the pediatrician uses the attached Pennsylvania state physical form.

A. After completing the examination, please return the form to the nurse. Please initial the appropriate response at the bottom of this letter and return it to the school nurse.

IV. No further action is needed if you have already submitted your child's physical form.

A. If your child has received a sports physical for any sport or activity during the current academic year, that examination will count for their required physical. Please initial the appropriate response at the bottom of this letter and return it to the school nurse.

V. Your child's pediatrician knows them best. However, if you would like your child to receive their annual physical examination at school, it will be conducted by Dr. Gardner in the spring. Please initial the box at the bottom of this letter and return it to the school nurse.

VI. **Please initialize the appropriate box to indicate how your child will receive their mandated physical examination. After completion, please sign, date, and return to the school nurse.**

STUDENT NAME:_____ Grade: _____		Initial
1	I allow the Laurel School District to have the school physician complete my child's annual physical examination in the Spring.	
2	My child will have the mandated physical exam performed by a private physician.	
3	My child has had a sports or regular pediatrician physical during the school year preceding their K, 6th, or 11th grade year. I will submit the proof of examination if I have not already done so.	

_____

Parent/Guardian Signature **Date**

Aimee Bookamer, CSN, RN
District Certified School Nurse K-12
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Tammy Casalandra
District School Nurse K-6
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PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

Student's name _____DOB:_____/_____/_____ Grade: _____

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

Other:

Complete the following section with a checkmark 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_____

PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

STUDENT NAME: _____ **GRADE:** _____ **DOB:** _____

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)

Date of exam_____**20**_____

Physical exam performed at: **Parent/guardian present during the exam: Yes** ⛀ **No** ⛀

Personal Health Care Provider's Office ⛀ **School** ⛀

Print name of examiner: _____ **Phone**_____

Signature of examiner_____ **MD** □ **DO** □ **PAC** □ **CRNP** □

PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

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)					

PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)