Lower Merion School District

WELCOME TO THE LOWER MERION SCHOOL DISTRICT

According to 28 PA.CODE CH 23.81 (School Immunization) and 28 PA.CODE CH 23.2 (Medical Examination), the following information must be provided:

1. **Evidence of Immunization**: The Pennsylvania Department of Health regulations require the exclusion from Pennsylvania Schools of any students who do not meet the following minimum immunization requirements:

   a. **Four doses of tetanus** (1 dose on or after the 4th birthday), usually given as DTP, DTaP, DT or Td.

   b. **Four doses diphtheria** (1 dose on or after the 4th birthday), usually given as DTP, DTaP, DT or Td.

   c. **Four doses of polio vaccine** (4th dose is not necessary if the 3rd dose was administered at age 4 years or older and at least 6 months after the previous dose).

   d. **Two doses of measles, mumps and rubella** (MMR) vaccine, one after 12 months of age and second doses of measles, mumps vaccine (preferably given as MMR).

   e. **Three doses of hepatitis B vaccine**, the first two doses given one month apart and the third dose six months after the first dose.

   f. **Evidence of varicella (Chicken pox) immunity:**
      1. **Date of varicella disease.**
      2. **Two doses of Varicella vaccine**

2. **Physical Examination:** The School Health Law requires medical examinations for children upon entrance to school and in grades 6 and 11. These grades were selected because they represent critical periods of growth and development in a child's life. It is recommended that these examinations be done by your family physician since they can best evaluate your child's health and assist you in obtaining necessary treatments and corrections, if needed.

   Please return the completed form as soon as possible to the School Nurse.

Lower Merion School District

REPORT OF PHYSICAL EXAMINATION

School:_____ **Examination Date:**_____

Name_____ _____**Birthdate**_____**Grade**____**Sex**____
Last *First*

Address _____ **Phone:**_____
 # Street *City* *Zip*

Vaccine	Doses									
	Please give exact dates									
DtaP DPT Td	1		2		3		4		5	
	6		7							
Tdap* (Adacel)	1		2							
Polio (OPV, IPV)	1		2		3		4		5	
Hepatitis B	1		2		3					
MMR	1		2							
Varivax #1			Varivax #2				Varicella (disease)			
Meningococcal*MCV							Other			
PPD			MM results		INH Therapy		Other			

Allergy_____ **Epi-pen** ____**Yes**____**No**
Medical History_____
_____
Surgical History_____
_____

Height _____**Weight** _____ **BMI for *Age Percentile*** _____ **BP**____/____ **Pulse**_____

	Normal		Normal
General Nutrition	☐	Neuro Muscular	☐
Skin	☐	Skeletal	☐
Ears	☐	Emotional Status	☐
Nose & Throat	☐	Hearing	☐
Glands	☐	Scoliosis (Bending Pos)	☐
Heart	☐	Speech	☐
Lungs	☐	Vision R: 20/ L: 20/	
Abdomen	☐	Wears Corrective Lens Yes ☐ No ☐	

Is this student currently under treatment? No ☐ Yes ☐ _____

Please list any current or long-term medications (reason for administration): _____
_____

Should this student have any physical restrictions? _____

Signature of Examining Physician_____**Phone**_____

Printed name _____**Office Stamp**_____

Lower Merion School District

Family Dentist Report

Entrance to school (K or 1), grade 3, 7

THE PENNSYLVANIA SCHOOL HEALTH LAW REQUIRES dental examinations upon entrance to school **(kindergarten or grade one), third and seventh grades**. It is strongly recommended that your family dentist perform the exam as he/she is the most familiar with your child's dental needs and will be able to provide follow up treatments, cleanings etc.

*****Examination forms completed by the family dentist should be returned to your child's school*****

Name: _____ **School:** _____ **Grade** _____

_____
(Home address)

The above named student visited my office on _____
(Date)

At that time (Please check below):

No dental corrections were necessary _____

All necessary corrections were made _____

Appointment for corrections scheduled _____

Topical Fluoride was applied _____

Fluoride tablets were prescribed _____

Please note any specific problems _____

_____

Signature of Dentist: _____

Name of Dentist: _____

Address (or office stamp): _____

Lower Merion School District

Phone: _____