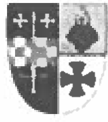

SACRED HEART
ELEMENTARY SCHOOL

Sacred Heart Elementary School | 325 Emerson Street | Pittsburgh, PA | 15206 |

(412) 441-1582 |

Dear Parents/Guardians of upcoming Kindergarten students,

Welcome to Sacred Heart Elementary School! We are so excited and honored that you have chosen our school to begin your child's educational journey. For enrollment, there are certain health requirements that must be met prior to starting. Please provide a complete immunization record. I have attached the state guidelines for reference. A pre-entrance physical and dental exam are also required as per the Pennsylvania Department of School Health's guidelines on school entry.

Thank you for your cooperation with meeting all these requirements. If you have any questions regarding these forms, please don't hesitate to contact me. I am looking forward to working with our new kindergarten students and their families for many years to come!

Sincerely,

Terri L. Rapp

Terri L. Rapp, CRNP, CSN

trapp2@pghschools.org

(412) 849-2984

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? 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: ________	☐ Yes	☐ No
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)

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

OVER

FREE AND LOW-COST DENTAL TREATMENT CENTERS AND INSURANCE FOR CHILDREN (rev. 02-21)

The School Dental Hygienists of the Pittsburgh Public Schools, Health Services have compiled the following list of FREE and LOW-COST dental treatment centers and health insurance agencies in the Pittsburgh area. If you do not have a family dentist, dental insurance, or cannot afford dental care, please contact any of the following dental clinics or agencies.

NOTE: ALL LOCATIONS ACCEPT MEDICAL ASSISTANCE

ALLEGHENY COUNTY PEDIATRIC DENTAL CLINICS – SERVES CHILDREN AGES 0 TO 20 FROM LOW IN-COME HOUSEHOLDS WHO CANNOT AFFORD PRIVATE DENTAL CARE.		
Central City Hill House Association 1835 Centre Avenue (15219) 412-392-4441	Mt. Oliver UPMC South Pittsburgh 1630 Arlington Avenue (15210) 412-432-1620	McKeesport Wander Building 339 5th Avenue (15132) 412-664-8858

************* LOW-COST DENTAL CARE *************

EAST	CENTRAL	WEST
Alma Illery Health Center 7727 Hamilton Avenue (15208) 412-244-4700	Catholic Charities Free Health Care Center 212 Ninth Street (15222) 412-456-6911	Terrific Teeth Pediatric Dentistry 1229 Silver Lane, Suite 2 (15136) 412-859-3199
E. Liberty Family Health Care Center Patients are being seen at: 807 Wallace Avenue (15221) 412-661-2802	Hill House Health Center 1835 Centre Avenue (15219) 412-697-4698	**NORTH**
Perfect Smile Dental (Shadyside) 715 N. Highland Avenue (15206) 412-661-7316	University of Pittsburgh Dental Clinic 3501 Terrace Street (15261) 412-648-8616	Allegheny Dental, Allegheny General Hosp. 320 E. North Avenue (15212) 412-359-3685
Squirrel Hill Health Center 4516 Browns Hill Road (15217) 412-697-7997	University of Pittsburgh Center for Patients with Special Needs. Ages 16 & Older Terrace Street Location 412-648-3039	Northside Christian Health Center 816 Middle Street (15212) 412-321-4001
Children's Hospital of Pittsburgh of UPMC 4401 Penn Avenue (15224) 412-692-5440	University Pittsburgh Pediatric Clinic Ages 16 & under & patients with special needs. Terrace Street Location 412-648-8930	Northview Heights Health Center 525 Mt. Pleasant Road (15214) 412-322-7500
Youth Smiles Dental Center 5918 Penn Avenue (15206) 412-361-5437	UPMC Presbyterian Dental Center 3459 Fifth Avenue (15213) 412-648-6730	**SOUTH**
		Cornerstone Care Community Health Center 500 Lewis Run Road, Suite 128 (15122) 412-228-3366
		Mt. Oliver Dental Pavilion 145 Brownsville Road (15210) 412-431-0232
		UPMC Children's South Dental Services 205 Millers Run Road (15017) 412-692-7337

Allegheny County – Dial 211: Helpline Center (Call for Any Service Needed)

PA CHIP/CARING PROGRAMS: Free or low-cost health insurance for children - 1-800-986-5437 https://www.chipcoverspakids.com

U.S. Healthcare CHIP Program: Free or low-cost health insurance for children – 1-800-318-2596 https://www.healthcare.gov

INTEREST FREE LOANS may be available from the Medical Bureau of Pittsburgh, a private, non-profit agency. Ask your dentist if he/she participates in this program before calling 412-539-0990. medicalbureau.org

EPSDT Program (EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT) provides comprehensive preventive, acute, and chronic care services for children under 21 who are eligible for Medical Assistance. ACCESS Plus Helpline 1-800-537-8862. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

Smile for a Lifetime Foundation: Nonprofit organization that provides free orthodontic care for those who qualify. Call 719-535-2777 or email info@SmileForALifetime.org for more information. Visit www.smileforalifetime.org

Pittsburgh Public Schools (PPS) does not discriminate on the basis of race, color, age, creed, religion, gender (including gender identity or expression), sexual orientation, ancestry, national origin, marital status, pregnancy or disability in its programs activities or employment and provides equal access to the Boy Scouts and other designated youth groups. Inquiries may be directed to the Assistant Superintendent for Student Services, Title IX Coordinator or the Section 504/ADA Title II Coordinator at 341 S. Bellefield Avenue, Pittsburgh, PA 15213, 412-529-3950, TitleIXCoordinator@pghschools.org or 412.529.HELP (4357).