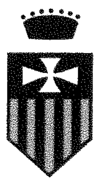

MERCY
CAREER & TECHNICAL HIGH SCHOOL

Forging Futures with Faith and Focus

2900 West Hunting Park Avenue
Philadelphia, PA 19129

215.226.1225

www.mercycte.org

May, 2020

Dear Parents and Guardians,

The following papers must be completed and on file at Mercy Career and Technical High School by August 1, 2020 in order for your son or daughter to begin classes in September. These requirements come from the School District of Philadelphia as well as the State of Pennsylvania. Mercy Career and Technical High School must be compliant.

The School District of Philadelphia Report of Physical Examination of School-Age Student. **Must be Completed and Signed by Physician or Nurse Practitioner. Physical must be within the past year.**

The School District of Philadelphia Pupil Medical History. The Student Health Status Form must be completed by parent/guardian.

Consent form for release of medical information

Please note:
All immunizations must be completed prior to the start of school.

For your information, the immunization schedule, provided by the School District of Philadelphia is included with this letter. For information about low-cost free health insurance for children call: **1-877-Kids-Now**.

Thank you for your complete cooperation with these state mandates. We appreciate your support so that your son/daughter may begin school on time in September.

Sincerely,

Christian Aument

Christian Aument
Principal

MERCY | CAREER & TECHNICAL HIGH SCHOOL

Forging Futures with Faith and Focus

The School District of Philadelphia

State law mandates that all students have a physical, dental, and health status form on file. If your child takes medications, they must bring the medication in the pharmacy labeled box with a Med-1 order. All students will be required to have a new physical form on file upon entry into 6th grade and again in 9th grade. Dental exams and forms are required upon entry into 3rd grade and 7th grade. Annual vision and growth screenings will also be required. Scoliosis screenings will take place in grades 6 and 7. Thank you for your attention to these matters.

_______ Physical (MEH-1)
_______ Dental (MEH-155)
_______ Health Status (S865)
_______ Medication Order (Med-1)

REQUIREMENTS

1. Section 1402 (a) of the School Code requires:
    1. Physical examinations upon entry and in grades 6 and 11
    2. Annual vision screening
    3. Annual growth screening
    4. Audiometric screening in grades K, 1, 2, 3, 7, 11 as well as annual testing for children who have failed previously
    5. Scoliosis Screening in grades 6 and 7
2. Section 1403 (a) requires:
    a. Dental examinations upon entry and in grades 3 and 7
3. Section 1402 (f) allows the School District of Philadelphia to modify the school health program with the approval of the Pennsylvania Secretary of health.

The School District of Philadelphia requires:

1. Audiometric screening in 6th rather than 7th grade, in 9th rather than 11th
2. Physical examinations in 9th rather than 11th grade.

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

REPORT OF PHYSICAL EXAMINATION

Name of Student	Date of Birth	Student ID #	Grade
Name of School	Room/Section/Book	Date Issued	

TO THE CARE PROVIDER (Please complete all items)

Pennsylvania law requires that students attending school in the state be immunized and receive periodic medical examinations. Payment for these examinations is the responsibility of the parent/guardian. THESE IMMUNIZATIONS ARE REQUIRED FOR SCHOOL ATTENDANCE.

RECORD OF VACCINE ADMINISTRATION

Please attach complete immunization record including serology results if available.

Allergies ______________________ Date of last PPD ______________ Result ____________ mm

Does this student have health insurance? ___ Yes ___ No Name of Insurance Provider: ______________________

RECORD THE FOLLOWING

1.	Visual Acuity: Without Glasses: R_____ L_____ With Glasses: R_____ L_____
2.	Audiometric Screening: R_____ L_____ / 3. BP__________
4.	Height __________inches / cm Weight __________lb. / kg BMI percentile __________
5.	Scoliosis Screening: ____ Normal ____ Abnormal ____ Referred ____ No Referral
6.	Activity Recommendation: ____ Full Physical Activity ____ Restricted Physical Activity (Must Complete Phys. Ed. Medical Exemption/Program Modification Form MEH-23) Specify Restrictions: ______________________
7.	List all medications currently being taken: Medication: ______________________ Reason: ______________________
8.	List ALL problems by history or examination: Circle status of problem 1. ______________________ Under Care Care Complete Referred 2. ______________________ Under Care Care Complete Referred 3. ______________________ Under Care Care Complete Referred ____ No Problems Identified

Comments / follow-up treatment plan / Special instructions to school:

Signature of Care Provider (REQUIRED)	Telephone Fax	Care Provider office stamp (REQUIRED)
Address	Date of Exam	

MEH-1 (Rev. 3/07) Comm. Code 61602445214

THE SCHOOL DISTRICT OF PHILADELPHIA

REPORT OF PRIVATE DENTAL EXAMINATION

Name of School	Student ID	Date Issued	
Name of Student	Date of Birth	Room/Section/Book	Grade

TO THE DENTIST

Pennsylvania law requires that students attending school in the Commonwealth receive periodic dental examinations at stated intervals (upon original entry, while in third grade, and while in seventh grade).

These examinations are required for school attendance. Payment for these examinations is the responsibility of the parent/guardian. If the student/family does not have health insurance the school nurse will help the family apply for health insurance. Please attach a copy of the student's dental examination or record the data below.

Thank you for your cooperation.

UNDER TREATMENT / WORK BEGUN	COMPLETION OF WORK / NO TREATMENT NECESSARY
Date Work Begun	☐ No Treatment Required Now
Scheduled Follow-up Appointment	☐ All Necessary Dental Work Completed
Date of Dental Examination	Expected Completion Date

Comments / Follow-up Treatment / Special Instructions to School

Name of Dentist	Telephone
Signature of Dentist	Date Signed
Address	Fax Number

IMPORTANT:

Return this form to:

____
Certified School Nurse/Practitioner

____
School

____
School Address

____
Phone Number

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

STUDENT HEALTH STATUS

LAST NAME		FIRST NAME		BIRTH DATE
SCHOOL NAME	ROOM/BOOK		GRADE	DATE OF ISSUE

■ **Please complete this form and return it to your school nurse immediately for the safe care of your child.**

To Parent/Guardian:

Your child's health record/history indicates that he/she has been under care for the following health problem(s):

____

1. Does the student's health problem(s) still exist? ____________________
2. Does he/she have other health problems? Yes ☐ No ☐ If yes, what are they? ____________________
3. Does he/she take medicine?
   Yes ☐ No ☐
   If yes, please give name of medicine, dosage, and time(s).

Medicine	Dosage	Time

4. Does he/she regularly receive treatment/therapy or undergo any testing procedures? ____________________
   If yes, please indicate kind and how often taken ____________________
5. Name of doctor, clinic or health center providing care for the student ____________________
   Address ____________________
   Phone # ____________ Fax # ____________ Date of last visit ____________
6. Insurance Provider ____________________

▶ **CONTACTS:**

Parent/Guardian: ____________________ Home Phone: ____________________

Work Phone: ____________________ Cell/Pager: ____________________

Parent/Guardian: ____________________ Home Phone: ____________________

Work Phone: ____________________ Cell/Pager: ____________________

Emergency Contact #1: ____________________ Phone # : ____________________

Emergency Contact #2: ____________________ Phone # : ____________________

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian ____________________ Date ____________

TO SCHOOL STAFF: SEE REVERSE SIDE FOR EMERGENCY CARE

SCHOOL NURSE	PHONE #

THE SCHOOL DISTRICT OF PHILADELPHIA

STUDENT MEDICAL HISTORY

Name of Student	Date of Birth	Date
Name of School	Room/Book/Section	Grade

Dear Parent/Guardian:

Pennsylvania law requires that all children must have a complete checkup when entering school for the first time and again in middle and high school.

The school nurse can help you with information regarding health insurance. There are free and low-cost insurance plans for which your family may qualify. Please take the attached form to your doctor or clinic when you take your child for this checkup and return the completed form to the school nurse by____________________

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply asneeded regarding my child's care.

*Parent/Guardian Signature*____________________ *Date*__________

STUDENT'S MEDICAL HISTORY - TO BE COMPLETED BY PARENT/GUARDIAN

1. Do you have health insurance? ___ Yes ___ No What is the name of your insurance?________________
2. Where do you take your child for checkups?________________ Phone:________ Fax:________
3. Date of child's last physical examination?________________
4. Where do you take your child for dental care? ________________ Phone:________ Fax:________
5. Date of child's last dental examination?________________
6. Does your child take any medicine now? ___ Yes ___ No, If yes, list below:
   - Medicine: ____________ How often ________ For what ________
   - Medicine: ____________ How often ________ For what ________
   - Medicine: ____________ How often ________ For what ________
7. Is your child allergic to anything? ___ Yes ___ No, If yes, to what________________
8. Does your child have any activity restrictions? ___ Yes ___ No, If yes, explain________________

PLEASE CHECK ANY PROBLEM YOUR CHILD HAS/HAS HAD

__ Asthma
__ Anemia
__ Arthritis
__ Behavior/Emotional
__ Blood Disorders
__ Cancer
__ Chicken Pox at age___
__ Dental
__ Diabetes
__ Drug/Alcohol
__ Eczema
__ Frequent Colds
__ Hearing Difficulty
__ Heart
__ High Blood Pressure
__ Hospitalized (Surgery)
__ Learning Problem
__ Lung Disease
__ Lead Poisoning
__ Meningitis
__ Muscle/Bone/Joint
__ Physical Disability
__ Premature Birth (Under 5 Lbs)
__ Seizures
__ Speech Difficulty
__ Tuberculosis
__ Vision Problems
__ Urinating/Kidney Problem

*Additional comments:*________________________