EASTERN LANCASTER COUNTY SCHOOL DISTRICT
New Holland, PA 17557

Dear Parent/Guardian,

The following information is needed to adequately begin your child's health record, which will be maintained throughout his/her school years. Return by _____.

_____ The check in sheet (including the Birth Certificate Number)
_____ Health Services Inventory – Both sides
_____ A **copy** of the Immunization Record

Pennsylvania State Law requires the following immunizations in order to attend Kindergarten/grade 1:

- 4 DPT (Diphtheria, Pertussis, Tetanus)
  The 4th DPT must be given on or after the 4th birthday.
- 3 Polio Vaccine
- 2 MMR (Measles, Mumps, Rubella)
- 3 Hepatitis B
  Dose #2 must be given a minimum of 28 days after dose #1;
  Dose #3 must be a minimum of 2 months after the 2nd dose
  and a minimum of 4 months after the first dose.
- Chickenpox: 2 doses of varicella given after the first birthday OR date of illness

The following two exam forms must be returned by or on the first day of school.

_____ Physical Exam - You may choose to have a Private Physician's Report completed by your family doctor and returned to the school nurse by the first day of school. If you choose not to have the physical exam completed by your family physician a school exam will be done by the school doctor.

_____ Dental Exam - You may choose to have the Family Dentist Report completed by your family dentist and returned to the school nurse by the first day of school. If you choose not to have the dental exam completed by your family dentist a school exam will be done by the school dentist.

Sincerely,
Gwen Clevenger, R.N.
Beth Fulmer, R.N.
Jacqueline Hollinger, R.N.
Joy Hoover, R.N.
School Nurses

EASTERN LANCASTER COUNTY SCHOOL DISTRICT
PUPIL CHECK-IN

Today's Date: _____ Name of Previous School: _____

Grade: _____

Student Name _____ (_____) Sex _____
Last First Middle Nickname M or F

Birthdate_____ Birth Certificate Number _____ Race Code _____ Amer Indian(I);
Month/Day/Year (file number) Black (B);Oriental Asian (A); Spanish Amer (H);
Multi-Racial (M); Caucasian (W)

City of Birth _____ State of Birth _____ County of Birth _____

Language Spoken in Home _____

Address _____ Phone Number _____

_____

City _____ State _____ Zip Code _____

Please circle appropriate title: Mr.& Mrs. Mr. Mrs. Miss Ms.
Please check ❑ if living with child

❑ Father _____ ❑ Mother _____
Last First Middle Last First Middle

❑ Guardian _____ ❑ Step-Parent _____
Last First Middle Last First Middle

❑ Significant Other _____

Status of Parents: Married ___ Separated ___ Divorced ___ Single ___
Mother Deceased ___ Father Deceased ____ Stepmother ____ Stepfather ____

Siblings and other children living within the home (full names please)

Name	Yr. Birth	Sex	Name	Yr. Birth	Sex

Eastern Lancaster County School District - Student Health Inventory

(to be completed by parent/guardian)

The information requested on this health profile will become a part of your child's confidential school health record.

Student's Full Name	Birth Date	Today's Date

Immunizations: Attach a copy of the student's immunization record or a doctor verified immunization record.

Has your child ever had any of the following illnesses? If yes give date.

☐ Chicken Pox ☐ Measles ☐ Rheumatic Fever ☐ Whooping Cough
☐ German Measles ☐ Mumps ☐ Scarlet Fever
☐ Hepatitis ☐ Meningitis ☐ Strep Throat
☐ Lead Poisoning ☐ Pneumonia ☐ Tuberculosis

INDICATE IF STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING:
If your child has a condition that requires medication or treatment at school contact the School Nurse to obtain the correct required forms.

Health Condition	No	Yes	Explanation if "Yes"
ADD/ADHD	☐	☐	Medication taken at home: Medication required at school:
Allergies to Medications	☐	☐	List:
Allergies to Food	☐	☐	Food(s): Rate the reaction: ☐mild ☐moderate ☐severe ☐life-threatening Does your child require Benadryl? ☐yes ☐no EpiPen? ☐yes ☐no
Allergy to Bee Stings	☐	☐	Rate the reaction: ☐mild ☐moderate ☐severe ☐life-threatening Does your child require Benadryl? ☐yes ☐no EpiPen? ☐yes ☐no
Allergies (other)	☐	☐	List:
Asthma	☐	☐	Rate the severity: ☐mild ☐moderate ☐severe ☐ life-threatening Medication taken at home: Medication required at school:
Blood Disorder	☐	☐	Specify: Treatment:
Bone/Muscle Problems	☐	☐	Specify: Activity Restrictions:
Bowel/Digestive Issues	☐	☐	Specify:
Cancer	☐	☐	Specify: Treatment:
Congenital abnormality/ Birth defect	☐	☐	
Diabetes	☐	☐	☐Type 1 (Insulin Dependent) ☐Type 2 Diabetes medication(s) taken at home:
Eating or Appetite Problems	☐	☐	Specify:
Eye or Vision Problems	☐	☐	☐Contacts ☐Glasses ☐for distance ☐for reading ☐Diagnosis:
Hearing Loss	☐	☐	☐Hearing Loss Right Ear ☐Hearing Loss Left Ear ☐Hearing Aid(s)
Heart Condition	☐	☐	Specify:
Kidney/Bladder problem	☐	☐	Specify:
Language/speech difficulties	☐	☐	
Migraine Headaches	☐	☐	Triggers: Treatment:
Mental Health Emotional/ Behavioral Issues	☐	☐	Specify: Treatment/Medication:
Seizure Disorder	☐	☐	Type of seizure: Seizure medication taken at home:
Serious Injury	☐	☐	Specify: Date(s):
Skin Problems/Eczema	☐	☐	Specify: Treatment:
Surgery	☐	☐	Specify: Date(s):
Other Serious Illness	☐	☐	Specify:
Medication Taken at Home *(if not already listed)*	List:		

Birth and Early Development History

Pregnancy:

- ☐ Illness during pregnancy _____
- ☐ Full Term
- ☐ Premature: _____ weeks
- ☐ Complications _____

- ☐ Natural Birth
- ☐ Cesarean Section
- ☐ Birth Injury: _____

Problems in the first week of life:

- ☐ Breathing difficulties
- ☐ Convulsions
- ☐ Infections
- ☐ Jaundice
- ☐ Feeding Difficulties

Early Growth:

- _____ Age child able to sit alone without support
- _____ Age child began to walk alone
- _____ Age child began to say two or three words together

Family Medical History

Has your child's parents, grandparents, siblings, aunts, uncles, had any of the following diseases or conditions?

			If answered yes, please give relationship to child
Allergies	☐ No	☐ Yes	
Asthma	☐ No	☐ Yes	
Cancer	☐ No	☐ Yes	
Diabetes	☐ No	☐ Yes	
Heart Disease	☐ No	☐ Yes	
High Blood Pressure	☐ No	☐ Yes	
Inherited Diseases	☐ No	☐ Yes	
Learning Disability	☐ No	☐ Yes	
Migraine / Headaches	☐ No	☐ Yes	
Other: List:			

Tuberculosis Exposure Assessment

Has your child had any contact with an adult with infectious tuberculosis?	☐ No	☐ Yes
Are you or your child foreign born or does anyone in your family travel outside the U.S.? Regions that are especially at high risk are Latin America, Mexico, Philippines, Caribbean Islands, Asia, and Africa.	☐ No	☐ Yes
Does your child have any of the following medical risk factors: Hodgkin's disease, lymphoma, diabetes, chronic renal failure, or malnutrition?	☐ No	☐ Yes
Does your child have an immunosuppressive condition such as HIV infection or has your child been exposed to individuals with HIV infection?	☐ No	☐ Yes
Is your child frequently exposed to adults in any of the following groups: Residents of nursing homes, migrant farm workers, IV drug users, homeless individuals, and incarcerated adolescents or adults?	☐ No	☐ Yes

Medical examinations are required on original entry (Kindergarten or Grade 1), Grades 6 and 11, and any other grade if moving in from out of state. You may choose to have these exams done by your family physician or it will be done at school by the school physician.

☐ School Physician OR ☐ Name of Family Physician _____ Phone Number: _____

Does your child have medical insurance: ☐ No ☐ Yes ☐ Private ☐ Medical Assistance

Dental examinations are required on original entry (Kindergarten or Grade 1), Grades 3 and 7, and any other grade if moving in from out of state. You may choose to have these exams done by your family dentist or it will be done at school by the school dentist.

☐ School Dentist OR ☐ Name of Family Dentist: _____ Phone Number:_____

Does your child have dental insurance: ☐ No ☐ Yes ☐ Private ☐Medical Assistance

- It is MANDATORY that pupils who show symptoms of communicable disease be excluded from classes until readmission is acceptable to school authorities according to school code.
- ElanCo school district recognizes that to insure good health and best educational conditions, it is sometimes necessary for pupils to receive medication during school hours. Refer to the "Administration of Medication" section of the District Handbook for details.
-Please contact the school nurse if there any changes in your child's health status.

This information will be shared in a confidential manner with appropriate school personnel as needed in order to provide for your child's educational, health and safety needs.

_____ _____ _____

PARENT/GUARDIAN SIGNATURE *PRINTED NAME* *DATE*