POPE JOHN PAUL II REGIONAL CATHOLIC ELEMENTARY

DATE:________________________ **PHONE:_____________________**

STUDENT NAME:__________________ **DATE OF BIRTH:______________**

GRADE ENTERING PJPII:_____ **SCHOOL YEAR:___________**

CERTIFICATE OF IMMUNIZATION

The Pennsylvania School Health Law states:

The following minimum immunizations are required for all students entering school for the first time or into Kindergarten.

- 4 doses – Tetanus (1 dose after the 4th birthday)
- 4 doses – Diphtheria (1 dose after the 4th birthday)
- 3 doses Polio
- 2 doses Measles – 2 doses Mumps – 1 dose Rubella (German measles)
- 3 doses of Hepatitis B
- 2 doses Varicella vaccine (chickenpox) or history of the disease

Children Entering 7th grade

- 1 dose of Meningococcal Conjugate vaccine (MCV)
- 1 dose Tetanus, Diphtheria, Accellular Pertussis (Tdap)
- If 5 years has elapsed since last Tetanus immunization

In accordance with the above State Regulations a child will not be admitted to school until his/her certificate of Immunization or exemption* is completed by a physician or other health care provider.

*The following is the position of the Church around the issue of immunization:

The Pontifical Academy for Life encourages Catholics to use alternative vaccines when they are available. Unfortunately, none exist at this time. For this reason, Catholics may use these vaccines with a clear conscience.

The Pontifical Academy also strongly encourages parents to vaccinate their children for the common good, since contact with a virus may cause serious harm to others, particularly in the case of a pregnant mother contracting the rubella virus.

For these reasons, the Church does not consider parents' objections as grounds for a "religious exemption" form vaccination.

A PHYSICAL EXAM is required for all students entering school for the first time.
Sixth graders are require to have a new physical.
All students coming from out of state are required to have a physical.

A DENTAL EXAM is required for all students entering school for the first time.
Third and Seventh graders are required to have a new Dental Exam.

PLEASE FILL-IN BELOW OR ATTACH A COPY OF THE IMMUNIZATIONS FROM THE DOCTOR

HEALTH HISTORY OF THE STUDENT (INITIAL)

Student's Name: ____________________________ **Grade: ___________**

Pre-natal health history:

Please put a circle around the answer
Explain if YES

Did the mother have any illness during the pregnancy? NO YES

Did the mother take any medicines or drugs (other than iron or vitamins) during the pregnancy? NO YES

Did the baby come on time? NO YES

Developmental history:

What was the birth weight of the baby? ____________

Did the baby have any trouble while in the hospital? NO YES

Did the baby have any special problems in the first six months? NO YES

At what age did the child sit alone without support? ____________

At what age did the child walk alone without support? ____________

At what age did the child begin to say two or three words together? ____________

Can the child use the toilet without help? NO YES

If the child has stopped wetting the bed, at what age did he or she stop? ____________

Family health history:

Circle any of the following diseases that the parents, grandparents, aunts, uncles, brother, or sisters of this child had:

Allergy, asthma, cancer, drug or alcohol addiction, heart disease, nervous breakdown, seizures, tuberculosis, lead poisoning, sickle cell, vision, hearing, learning problems, anema, other inherited or family diseases.

Past History:

Please put a circle around the answer
Explain if YES

Has the child ever been in the hospital or had an operation? NO YES
When? What for? Name of Hospital

Has the child had any other illnesses, accidents, broken bones, or stitches? NO YES
When? What for? Name of Hospital

3. Has the child ever been tested for lead poisoning? NO YES
   What was the result and treatment if needed?

Family Members:
(Note any special relationship such as step-parent, adopted, foster-child, etc.)

Relationship/ Name	**Birthdate**	**State of Health**	**Occupation/School**	**Grade Reached in school**
Mother				
Father				
Brothers				
Sisters				

How many people live in the same house as the child? ____________

Is there a baby-sitter for before or after school?	NO	YES

Name of sitter	**Address**	**Phone Number**

Health History (continued):

Please put a circle around the answer
Explain if YES

Has the child had more than six colds or throat infections (with a fever) a year?	NO	YES
Has the child had any trouble with ears or hearing?	NO	YES
Has the child had any trouble with eyes or seeing?	NO	YES
Has the child had any trouble with teeth?	NO	YES
Has the child ever had a convulsion (seizure)?	NO	YES
Has the child ever had a fainting spell?	NO	YES
Does the child complain of headaches?	NO	YES
Has the doctor ever said the child had a heart murmor?	NO	YES
Does the child have trouble keeping up with other children?	NO	YES
Do any foods disagree with the child?	NO	YES
Does the child often have diarrhea?	NO	YES
Has constipation ever been much of a problems for this child?	NO	YES
Has the child ever had worms or parasites?	NO	YES
Have you ever seen blood in the child’s stools (bowel movements)?	NO	YES
Has the child ever had yellow jaundice or trouble with the liver?	NO	YES

Check any of the following illnesses the child has had | Date they had illness

_____ "Red Measles" __________________
_____ Whooping Cough __________________
_____ Rheumatic Fever __________________
_____ German or "3 Day" Measles __________________
_____ Chicken Pox __________________
_____ Pneumonia __________________

Health History (continued):

Please put a circle around the answer
Explain if YES

Does the child have any allergies or asthma (foods, environmental, drugs, insects, etc.)? NO YES
Please list allergies and treatment:

18. Does the child take any medication on a regular basis? NO YES
Please list medication What for? Dose

Who is the child's doctor?
Name of doctor ____________________________ Last visit ________________

Who is the child's dentist?
Name of dentist ____________________________ Last visit ________________

Does the child have insurance for:
Medical visits? NO YES
Dental visits? NO YES
Vision? NO YES

Please put a circle around any of the following things which worry you about the child:

1. Bedwetting
2. Wetting during the day
3. Thumbsucking
4. Stammering or stuttering
5. High stung or easily upset
6. Too restless
7. Shy
8. Sad and sulky
9. Feelings easily hurt
10. Wanting too much attention
11. Wanting too much comfort or support from a parent
12. Daydreams
13. Nightmares
14. Temper tantrums
15. Contrary of stubborn
16. Disobedient
17. Lying
18. Selfish in sharing
19. Jealous of brothers/sisters
20. Fighting with other children
21. Purposedly destroys things
22. Feeding
23. Bowels
24. Any other problems not mentioned? What?

____
Parent/Guardian Signature

____
Date

Coatesville Area Catholic
Elem. School
605 East Lincoln Highway
Coatesville, PA 19320

COATESVILLE AREA SCHOOL DISTRICT
COATESVILLE, PENNSYLVANIA

HEALTH HISTORY PERMISSION FORM (INITIAL HISTORY)

STUDENT NAME: ______________________________

THE NATURE OF THIS HEALTH HISTORY

I understand that the information I give to the School Nurse is important for the school staff to understand and help the health and education of my child.

I understand that the information will be kept confidential by the School Health Staff, and will be shared with other professionals in the school and in other institutions only when the School Nurse/Nurse Practitioner/School Physician believes that it is in the best interest of my child's health and education.

Copies of this health history will be sent to other agencies who request it only with my written permission.

______________ ______________________________

Date Signature of Parent/Guardian

EXPLANATION OF HEALTH SERVICES

The following health services are provided to every student in the Coatesville Area School District in compliance with Pennsylvania State Law:

Every year every student:	Height, weight, vision screening
K,1,2,3,7 and 11th Grade:	Hearing screening
K,3, and 7th Grade:	Dental-by school/family dentist
K,6, and 11th Grade:	Physical-by school/family doctor
6th and 7th Grade	Scoliosis screening

I understand the above screening and examination results will become a part of my child's permanent health record.

______________ ______________________________

Date Signature of Parent/Guardian

Name ____________________ Birthdate ____________________

Address ____________________ Parent or Guardian ____________________

____________________ Telephone ____________________

Race/Ethnicity: ☐ White ☐ Black ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native

Hispanic Origin: ☐ Yes ☐ No

Please Circle Present Grade K 1 2 3 4 5 6 7 8 9 10 11 12 Other ________

PENNSYLVANIA DEPARTMENT OF HEALTH – CERTIFICATE OF IMMUNIZATION

VACCINE Circle appropriate item	Enter Month, Day, and Year Each Immunization Was Given DOSES				
Diphtheria and Tetanus (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, Diphtheria and Acellular Pertussis (Tdap)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /
Measles - Mumps - Rubella (MMR)	1 / /	2 / /	or Measles Serology Date		Titler
Varicella (Vaccine or Disease)	1 / /	2 / /	Rubella Serology Date		Titler
Meningococcal (MCV)	1 / /	2 / /			
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		

Age appropriate dose of MCV and Tdap are required for entry into 7th grade.

H502.320 Rev. 12/05

Name ____________________ Birthdate ____________________

Address ____________________ Parent or Guardian ____________________

____________________ Telephone ____________________

Please Circle Present Grade K 1 2 3 4 5 6 7 8 9 10 11 12 Other ________

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

MEDICAL EXEMPTION

The physical condition of the above-named child is such that immunization would endanger life or health.

Signed ____________________ Date ____________________
(PHYSICIAN)

RELIGIOUS EXEMPTION

(Includes a strong moral or ethical conviction similar to a religious belief.)

Parent or guardian of the above-named child adheres to a religious belief whose teachings are opposed to such immunizations.

State your reason for requesting a religious exemption ____________________

____

____

Signed ____________________ Date ____________________
(PARENT OR GUARDIAN)