Union Area School District

2106 Camden Avenue • New Castle, Pennsylvania 16101 • ☎ 724-658-4501 • FAX 724-658-8617

ROB J. NOGAY, MEd, Middle/High School Principal

STUDENT HEALTH SURVEY

Welcome to Union Area School District. In order to provide the best care possible for your student while at school, please complete and return this form as soon as possible to the school nurse. Please mark (√) YES or NO beside any chronic condition your student is being treated for. Please list any important medical information you wish the school nurse to be aware of.

If you have any questions contact the school nurse. Thank you for your help in maintaining your student's health and safety while at school.

Mrs. Trocci, RN, BSN, CSN
Mrs. Benedict, RN, BSN, CSN

Student Name: _____ Grade: _____

CHRONIC CONDITIONS	YES	NO
Arthritis/Rheumatic Disease		
Asthma		
Attention Deficit Disorder/Hyperactivity		
Bleeding Disorder/Cooley's Anemia		
Cardiovascular Condition		
Cerebral Palsy		
Cystic Fibrosis		
Diabetes Type I or Type II		
Epilepsy/Other Seizure Disorders		
Life Threatening Food Allergies		
Sickle Cell Disease		
Spina Bifida		
Tourette's Syndrome		
Other		

_____

_____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

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ROB J. NOGAY, MEd, Middle/High School Principal

Dear Parent/Guardian:

In accordance with Pennsylvania School Code Section 1303 all students shall be immunized against certain diseases in order to safeguard the school community from the spread of certain communicable diseases. A review of your child's immunization record indicates noncompliance with the mandated immunization requirements.

A student may be exempt from the requirements of immunization if a physician certifies the child's physical condition contraindicates immunization or if the parent/guardian objects immunization based on a religious or strong moral/ethical conviction.

Statements of religious or strong moral/ethical conviction opposing immunization must be submitted in writing and signed by the parent/guardian. Please submit your opposition in writing and sign the attached form and return to the school nurse ASAP.

In the event of a disease outbreak, your child may be exempt from school for their health and safety.

Sincerely,
Mrs. M. Trocci, RN, BSN,CSN
Mrs. D. Benedict, RN,BSN,CSN
School Nurse, Union Area School District

Statement of Exemption to Immunization Law

Commonwealth of Pennsylvania

Name _____ **Date of Birth** _____

Address _____

Phone _____ **Grade** _____

☐ **Medical Exemption**[a] The physical condition of the above named child is such that immunizations would endanger life or health.

Other Comment: _____

Physician Signature: _____ Date: _____

☐ **Religious Exemption**[b] (Includes a strong moral or ethical conviction similar to a religious belief.)

Parent or guardian of the above name child adheres to a religious belief whose teachings are opposed to such immunizations OR holds a strong moral or ethical conviction similar to a religious belief that is opposed to such immunizations.

Other Comments/Explanation: _____

Signature Parent/Guardian: _____ Date: _____

PA 28§ 23.84. Exemption for immunization.

(a) *Medical exemption.* Children need not be immunized if a physician or designee provides a written statement that immunization may be detrimental to the health of the child. When the physician determines that immunization is no longer detrimental to the health of the child, the child shall be immunized according to this subchapter.

(b) *Religious exemption.* Children need not be immunized if the parent, guardian or emancipated child objects in writing to the immunization on religious grounds or on the basis of a strong moral or ethical conviction similar to a religious belief.

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ROB J. NOGAY, MEd, Middle/High School Principal

School Vaccination Requirements for Attendance in Pennsylvania Schools

Students in ALL grades (K-12) need the following immunizations for school attendance:

- 4 doses of DTaP (Diphtheria, Tetanus and Acellular Pertussis) -1 dose on or after 4th birthday
- 4 doses of Polio - 1 dose on or after 4th birthday and at least 6 months after previous dose given
- 2 doses of MMR (Measles, Mumps, Rubella)
- 3 doses of Hepatitis B
- 2 doses of Varicella (Chicken Pox) or evidence of immunity

7th Grade ADDITIONAL immunization requirements for school attendance:

- 1 dose of MCV (Meningococcal Conjugate Vaccine)
- 1 dose of Tdap (Tetanus, Diphtheria, Acellular Pertussis)

12th Grade ADDITIONAL immunization requirements for school attendance:

- 2nd dose of MCV (Meningococcal Conjugate Vaccine) - Student must be age 16 or entering 12th grade

These requirements allow for the following exemptions: medical reasons, religious beliefs, or philosophical/strong moral or ethical conviction. Even if your child is exempt from immunizations, he/she may be excluded from school during an outbreak of vaccine preventable disease. Children without proof of proper immunization will not be allowed to start school. If you are underinsured or have concerns with cost, the Pennsylvania Department of Health in New Castle offers immunization clinic dates: Contact number 724-656-3088.

Mrs. Trocci, RN, BSN, CSN
Mrs. Benedict, RN, BSN, CSN

Immunizations Needed:

_____

_____

_____

Union Area School District

2106 Camden Avenue • New Castle, Pennsylvania 16101 • ☎ 724-658-4501 • FAX 724-658-8617

ROB J. NOGAY, MEd, Middle/High School Principal

Dear Parent/Guardian of _____

Pennsylvania's school immunization code requires all students to receive 1 dose of MCV (meningococcal conjugate vaccine) and 1 dose of Tdap (tetanus, diphtheria, acellular pertussis) by the first day of 7th grade.

At present, our records indicate that your child will need these immunizations upon entry of the 2024-2025 school year to avoid risk of exclusion. Please schedule an appointment with your child's physician soon to meet these state requirements. Please call the school health office with any questions and thank you for your cooperation.

Sincerely,

Mrs. Trocci, RN, BSN, CSN
Mrs. Benedict, RN, BSN,CSN
724-658-4501, Ext. 2104

Union Memorial Elementary School

500 South Scotland Lane • New Castle, PA 16101-1399 • (724) 652-6683 • FAX (724) 658-5151

LINDA J. O'NEILL - Elementary Principal

School Vaccination Requirements for Attendance in Pennsylvania Schools

Students in ALL grades (K-12) need the following immunizations for school attendance:

- 4 doses of DTaP (Diphtheria, Tetanus and Acellular Pertussis) -1 dose on or after 4th birthday
- 4 doses of Polio - 1 dose on or after 4th birthday and at least 6 months after previous dose given
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- 2 doses of Varicella (Chicken Pox) or evidence of immunity

7th Grade ADDITIONAL immunization requirements for school attendance:

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- 2nd dose of MCV (Meningococcal Conjugate Vaccine) - Student must be age 16 or entering 12th grade

These requirements allow for the following exemptions: medical reasons, religious beliefs, or philosophical/strong moral or ethical conviction. Even if your child is exempt from immunizations, he/she may be excluded from school during an outbreak of vaccine preventable disease. Children without proof of proper immunization will not be allowed to start school. If you are underinsured or have concerns with cost, the Pennsylvania Department of Health in New Castle offers immunization clinic dates: Contact number 724-656-3088.

Mrs. Trocci, RN, BSN, CSN
Mrs. Benedict, RN, BSN, CSN

Immunizations Needed:

_____

_____

_____

Union Memorial Elementary School
500 South Scotland Lane • New Castle, PA 16101-1399 • (724) 652-6683 • FAX (724) 658-5151
LINDA J. O'NEILL - Elementary Principal

Just a Reminder...

We have experienced a lot of absenteeism in the past few weeks here at the school and we are trying to get everyone well again and back to school.

As a parent/guardian, please use good judgement in deciding whether to send your child to school if they are not feeling well. If your child is ill or recovering from an illness, please follow these guidelines before sending them to school:

1. No fever for a full 24 hour period. If a fever (a temperature of 99.6 F or higher) is present in the morning, please do not medicate them and send them to school. The fever will most likely return in 3 to 4 hours necessitating a call home.
2. A persistent, congested cough for 3 to 4 days should be treated by a physician. Most respiratory illnesses are spread by air droplets through coughing and sneezing.
3. A child who experienced vomiting throughout the night should be kept home. They most likely will become ill again after eating food.
4. A child with a rash should be seen by the nurse or your physician before attending school to determine if they are contagious.
5. Encourage good hygiene and frequent hand washing with your child.
6. Do not share drinking cups and eating utensils.

We appreciate your cooperation in keeping all our children well and healthy. Please feel free to call with any questions or concerns at 724-652-6683.

Sincerely,
Mrs. Trocci, RN, BSN, CSN
Mrs. Benedict, RN, BSN, CSN

Union Memorial Elementary School
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LINDA J. O'NEILL - Elementary Principal

School Vaccination Requirements for Attendance in Pennsylvania Schools

Students entering Pre-K need the following immunizations for school attendance:

- 3 doses of DTaP (Diphtheria, Tetanus and Acellular Pertussis) -1 dose on or after 4th birthday
- 3 doses of Polio - 1 dose on or after 4th birthday and at least 6 months after previous dose given
- 1 dose of MMR (Measles, Mumps, Rubella)
- 3 doses of Hepatitis B
- 1 dose of Varicella (Chicken Pox) or evidence of immunity

These requirements allow for the following exemptions: medical reasons, religious beliefs, or philosophical/strong moral or ethical conviction. Even if your child is exempt from immunizations, he/she may be excluded from school during an outbreak of vaccine preventable disease. Children without proof of proper immunization will not be allowed to start school. If you are underinsured or have concerns with cost, the Pennsylvania Department of Health in New Castle offers immunization clinic dates: Contact number 724-656-3088.

Mrs. Trocci, RN, BSN, CSN
Mrs. Benedict, RN, BSN, CSN

Immunizations Needed:

_____

_____

_____

Union Memorial Elementary School

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LINDA J. O'NEILL - Elementary Principal

KINDERGARTEN / 1ST GRADE PHYSICAL EXAMINATION REQUIREMENT

Dear Parent/Guardian:

The Pennsylvania School Code requires a **Physical Examination** be completed on every student **entering school for the first time in either Kindergarten or 1st Grade.** Your private physician is the best person to perform the examination, since they know your child's medical history.

Union Area School District can provide your child with a Physical Examination. This examination CANNOT be completed in school without your WRITTEN PERMISSION. Please sign this form and indicate your choice below.

If you plan to have your own physician perform this examination, have them complete the attached form and return it to the school nurse ASAP. THE EXAMINATION FORM MUST BE DATED NO EARLIER THAN ONE YEAR PRIOR TO SCHOOL ENTRY. Examination forms dated earlier are not valid and cannot be accepted.

Thank you for your cooperation.

Sincerely,
Mrs. Trocci, RN, BSN, CSN
Mrs. Benedict, RN BSN, CSN

Student Name:_____

____ I will take my child to my **family physician** and return the form to the health office.

____ I would like the examination completed by the **school physician.**

Parent/Guardian Signature:_____

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? ☐ Yes ☐ No 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: _____		
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 ☐ Asthma/lung problems ☐ Behavioral health issue ☐ Diabetes ☐ Inherited disease/syndrome ☐ Kidney problems ☐ Seizure disorder ☐ 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 ☐ Cardiomyopathy ☐ High blood pressure ☐ High cholesterol ☐ QT syndrome ☐ Marfan syndrome ☐ Ventricular tachycardia ☐ 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 _____

STUDENT NAME:

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)					

Union Memorial Elementary School
500 South Scotland Lane • New Castle, PA 16101-1399 • (724) 652-6683 • FAX (724) 658-5151
LINDA J. O'NEILL - Elementary Principal

Kindergarten/1st Grade Dental Examination Requirement

Dear Parent/Guardian:

The Pennsylvania School Code requires that a **Dental Examination** be completed on every student **entering school for the first time in either kindergarten or first grade.** Your private dentist is the best person to perform the examination, since they know your child's dental history.

Union Area School District can also provide your child with a Dental Examination. The dental examination CANNOT be completed in school without your WRITTEN PERMISSION. Please sign this form and indicate your choice below.

If you plan to have your own dentist perform this examination, have them complete the attached form and return it to the school nurse ASAP. THE EXAMINATION MUST BE DATED NO EARLIER THAN ONE YEAR PRIOR TO THE CURRENT SCHOOL YEAR. Examination forms dated earlier are not valid and cannot be accepted.

Thank you for your cooperation.

Sincerely,
Mrs. Trocci, RN, BSN, CSN
Mrs. Benedict, RN, BSN, CSN

Student Name:_____

____I will take my child to my **private dentist** and return the form to the health office.

____I would like the examination completed by the **school dentist.**

Parent/Guardian Signature:_____

Union Memorial Elementary School

500 South Scotland Lane • New Castle, PA 16101-1399 • (724) 652-6683 • FAX (724) 658-5151

LINDA J. O'NEILL - Elementary Principal

Dental Examination
Parent Permission

Dear Parent/Guardian:

The Pennsylvania School Code requires that a **Dental Examination** be completed on every student in **3rd and 7th Grade**. Your private dentist is the best person to perform the examination, since they know your child's dental history.

Union Area School District can also provide your child with a Dental Examination. The dental examination CANNOT be completed in school without your WRITTEN PERMISSION. Please sign this form and indicate your choice below.

If you plan to have your own dentist perform this examination, have them complete the attached form and return it to the school nurse ASAP. THE EXAMINATION MUST BE DATED NO EARLIER THAN ONE YEAR PRIOR TO THE CURRENT SCHOOL YEAR. Examination forms dated earlier are not valid and cannot be accepted.

Thank you for your cooperation.

Sincerely,
Mrs. Trocci, RN, BSN, CSN
Mrs. Benedict, RN, BSN, CSN

Student Name:_____

____I will take my child to my **private dentist** and return the form to the health office.

____I would like the examination completed by the **school dentist**.

Parent/Guardian Signature:_____

H514.027

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 or 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