

WEST SHORE SCHOOL DISTRICT



Dear Parent/Guardian:

A healthy child is a productive child. Our goal in the West Shore School District is to make your child's school experience as healthy as possible. Despite all efforts to minimize illness, any place where children are in close proximity to one another (sporting events, dance classes, play-dates, sleep-overs, church activities, scouting events, local parks and playgrounds, shopping centers and schools) allows for the exposure of your child to contagious illnesses and the dreaded incursion of head lice.

Unfortunately, head lice have been in existence for thousands of years and will continue to be commonly found in all locations where humans reside, including all of our schools. The good news is, armed with some basic knowledge and by carrying out a few easy steps; a proactive parent can lessen the likelihood of their child developing a lice infestation. As parents, we are always on the lookout for the obvious sneezes, sniffles and coughs, but often forget to do a weekly inspection of our child's head for lice. Research shows that the average head has been infested with lice for at least one month prior to the development of symptoms. Therefore, a weekly head check is key in the early detection and treatment of head lice. As such, the health services department would like to share some important reminders about head lice.

The head louse lays its nits (eggs) on the hair shaft near the scalp. A live louse and its nits are most often found behind a child's ears, in bangs and at the base of the neck. The adult louse is about the size of a sesame seed (2-3 mms) in length. The nits look like a fleck of dandruff; they do not brush off the hair shaft, but instead need to be scraped off with your fingernail. To help you deal with this common problem, the following preventative measures are suggested.

1. **Always check your child's head at least once a week throughout the school year. Be vigilant; do not wait to hear that another child has lice before you begin to check your own child for lice.** Please remember there always have been and always will be lice anywhere children gather, including our schools.
2. Remind your children to avoid head-to-head contact with other children and not to share their hats, combs, brushes, barrettes, and headphones with others.
3. Be sure to wash your child's hair frequently.
4. Be mindful of the early warning signs such as head scratching or the appearance of white specks that remain in the hair.
5. Wash hats, scarves, hair ribbons, combs, brushes, and other hair accessories at least once a week.
6. Outer clothing that comes in contact with the head or neck should be washed frequently.
7. Inspect your child's head especially before and after a group activity such as a slumber party or camping activity.
8. If lice are found, have a high index of suspicion that many, if not all, family members may also be infested and treat accordingly.
9. Stop the spread of lice. Notify neighbors, friends, and playmates that have been in contact with your child.



photo enlarged

In spite of all these precautions, your child may still get head lice if the appropriate conditions occur. A head louse's only requirement is a warm host on which to live and breed. Head lice do not discriminate by socioeconomic class and are just as happy living in "clean" as well as "dirty" hair. If your child happens to acquire lice, don't panic, head lice are pests, but do not carry any diseases. Our best advice to parents is to treat ALL family members that are infested with a commercially approved louse killing shampoo, remove ALL nits so they do not hatch and re-infest the head, and treat all surfaces that a head or hair may come in contact with in the home. Despite all your efforts, lice can be very frustrating and difficult to eradicate. Through years of experience in dealing with lice, school nurses have found that the more effort you put into their initial removal, the better chance you have of totally eliminating a reoccurrence of lice.

On the school front, please be assured that if the school district becomes aware of a case of head lice we will follow the latest expert recommendations from the Center of Disease Control and Prevention and the American Academy of Pediatric Physicians on the management of head lice in the school environment. If you have questions about your child's head lice, or if you find head lice in your child's hair, please contact the school nurse. We understand that some parents may fear the perceived stigma that can be associated with head lice, therefore, may be hesitant to report this information to the school. Please be assured that the school will not share this information with others, as is our practice with any non-life threatening condition, and will maintain your child's medical privacy. Your child's school nurse would like to be a trusted resource and hopes parents/guardians are comfortable coming to us so we can convey our knowledge and help you eradicate head lice in your home, and thus our schools. For more information on this and many other health related topics, please visit our Health Services Webpage at: <http://www.wssd.k12.pa.us/HealthServices.aspx>

Respectfully, WSSD Health Services Staff



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: <i>Has the student...</i>	YES	NO
1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <i>Has the student...</i>	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: <i>Has the student...</i>	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: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> 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: <i>Has the student...</i>	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: <i>Has the student...</i>	YES	NO
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: <i>Has the student...</i>	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
SOCIAL/LEARNING: <i>Has the student...</i>	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: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> 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'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes No

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	* ABNORMAL	DEFER	
Height: () inches				
Weight: () pounds				
BMI: ()				
BMI-for-Age Percentile: () %				
Pulse: ()				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected <input type="checkbox"/>				
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				
	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT					
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td					
Polio Type: OPV or IPV					
Hepatitis B (HepB)					
Measles/Mumps/Rubella (MMR)					
Mumps disease diagnosed by physician <input type="checkbox"/>	Date: _____				
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>					
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella					
Meningococcal Conjugate Vaccine (MCV4)					
Human Papilloma Virus (HPV) Type: HPV2 or HPV4					
Influenza Type: TIV (injected) LAIV (nasal)	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)					
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13					
Hepatitis A (HepA)					
Rotavirus					
Other Vaccines: (Type and Date)					

