SHALER AREA SCHOOL DISTRICT
NURSING DEPARTMENT

High School
Leslie Scheuer, RN, CSN
492-1200 X 1510
492-1267 (FAX)

Middle School
Christina Erdien, RN, CSN
492-1200 X 2510
492-1237 (FAX)

Elementary School
Kim Armstrong, RN, CSN
492-1200 X 3510
492-1317 (FAX)

Burchfield/ Rogers
Audrey Gaskill, RN, CSN
492-1200 X 4510
486-7631 (FAX)

Marzolf/Jeffery/Reserve
Lori Matz, RN, CSN
492-1200 X 6510 (M)/5810 (J)/7510 (R)
486-8702 (FAX-Marzolf)
492-1287 (FAX-Jeffery) 321-4507 (FAX-Reserve)

Montessori/ /Adelphoi Village
Kim Armstrong, RN, CSN
492-1200 X 3510

NAME OF SCHOOL _____ GRADE _____ DATE _____

NAME OF CHILD _____

ADDRESS _____

No. and Street _____ City _____ Boro or Township _____ County _____ State _____ Zip Code _____

MEDICAL HISTORY
IMMUNIZATIONS AND TESTS

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 / /
Tdap	1 / /				
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	
Hepatitis B	1 / /	2 / /	3 / /		
Measles-Mumps-Rubella (MMR)	1 / /	2 / /	Or Measles Serology: Date		Titer
Varicella	1 / /	2 / /	Rubella Serology: Date		Titer
Meningitis	1 / /		Mumps disease diagnosed by a physician: Date		
Other	1 / /	2 / /			

☐ MEDICAL EXEMPTION (The physical condition of the above named child is such that immunization would endanger life or health.)

☐ RELIGIOUS EXEMPTION (Include a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian.)

Should this student have restrictions in physical education activities? [] Yes [] No

Recommendations:

_____

_____

Significant Medical Conditions (x)

	Yes	No	If Yes, Explain
Allergies	___	___	_____
Asthma	___	___	_____
Cardiac	___	___	_____
Chemical Dependency	___	___	_____
Drugs	___	___	_____
Alcohol	___	___	_____
Diabetes Mellitus	___	___	_____
Gastrointestinal Disorder	___	___	_____
Hearing Disorder	___	___	_____
Hypertension	___	___	_____
Neuromuscular Disorder	___	___	_____
Orthopedic Condition	___	___	_____
Respiratory Illness	___	___	_____
Seizure Disorder	___	___	_____
Skin Disorder	___	___	_____
Vision Disorder	___	___	_____
Other (Specify)	___	___	_____

Report of Physical Examination (x)	Normal	Abnormal	If Abnormal, Explain
Height (inches)			
Weight (pounds)			
Pulse ( )			
Blood Pressure /			
Hair/Scalp			
Skin			
Eyes – Visual Acuity R___/___/___/___			
Eyes – Color Vision			
Ears – Hearing dB R L			
Nose and Throat			
Teeth and Gingiva			
Lymph Glands			
Heart – Murmur, etc.			
Lung – Adventious Findings			
Abdomen			
Genitalia			
Neuromuscular System			
Extremities			
Spine (Presence of Scoliosis)			

_____
Date of Examination

_____ _____
Signature of Examiner Print Name of Examiner

_____
Address