Our goal at Hill Top Preparatory School is to provide your child with a safe environment during school hours. In order to best serve you child, Hill Top requests the following forms:

EMERGENCY MEDICAL FORM:
To be completed for
ALL STUDENTS

PHYSICAL EXAMINATION FORM:
To be completed for
NEW STUDENTS
STUDENTS ENTERING SIXTH AND ELEVENTH GRADE
STUDENTS WHO WILL BE PARTICIPATING IN AFTERNOON SPORTS (INCLUDING OUTDOORSMANSHIP)

ADMINISTRATION of MEDICATION at SCHOOL FORM:
To be completed for
STUDENTS WHO WILL TAKE MEDICATION AT SCHOOL
All medications are administered through the nurse's office. Students are not permitted to carry medication with them.The exception is an inhaler or EpiPen with written permission from parent and physician. If a student takes medication in the morning prior to school it is strongly suggested to keep an extra dose at school in case of a missed dose at home.

MEDICAL HISTORY for THORNCROFT EQUESTRIAN CENTER FORM:
To be completed for
STUDENTS WHO WILL PARTICIPATE AT THORNCROFT

DENTAL EXAMINATION FORM:
To be completed for
NEW STUDENTS
STUDENTS ENTERING SEVENTH GRADE

HILL TOP PREPARATORY SCHOOL - STUDENT EMERGENCY CARD

Student's Name: Home Phone: ( )

Date of Birth: Resides With: Mother______ Father_______ Both_______ Grade:

Address: City, State, Zip:

Parent (1) Name: **Parent (2) Name:**

Home Phone: Home Phone:

Business Phone: Business Phone:

Cell Phone: Cell Phone:

If parent or guardian cannot be reached, please contact:

1) Name: 2) Name:

Phone: Phone:

Physician: Physician Phone:

Dentist: Dentist Phone:

Is your child allergic to any food, drug, animal, or other substance? Yes__________ No___________

Please list conditions that require special attention (i.e. asthma, ADHD, seizures, diabetes):

Please list all medications taken in a 24-hour period (including dose and frequency):

My child wears (please circle) GLASSES CONTACTS HEARING AIDS BRACES/RETAINER OTHER DEVICES

Prescription medication **must be dispensed in the Health Room with a note from the Healthcare Provider and parent. Medications must be in original pharmacy labeled bottle with student's name, physician name, date, drug name, dose, and directions for use.** ***Non-prescription medication*** **must be dispensed in the Health Room and accompanied by a note from a parent. It must be in original labeled package.**

I GIVE MY PERMISSION TO ADMINISTER:

Tylenol / Acetaminophen	Yes ______	No ______
Advil-Motrin / Ibuprofen	Yes ______	No ______
Benadryl	Yes ______	No ______
Tums / Antacid	Yes ______	No ______

I AUTHORIZE SCHOOL ADMINISTRATORS TO MAKE NECESSARY ARRANGEMENTS IN AN EMERGENCY IF I AM UNAVAILABLE BY PHONE, AND TO INITIATE PROPER EMERGENCY MEDICAL SERVICES.

SIGNATURE OF PARENT / GUARDIAN DATE: _________

Health Insurance Company: Policy Number: ____________________

Hill Top Preparatory School
PHYSICAL EXAMINATION

School Year: ___________

This portion to be completed by **PARENT**:

Name of Student: ____Gender: __________Grade:________

Address of Student: ____DOB:___________________________

Has your child had any of the following? Please check and give details or date.

Allergies____ Surgery____

Asthma____ Infection____

Recurring Illness____ Diabetes____

Cardiac____ Seizure Disorder______________________________________

Other____

………

This portion to be completed by **PHYSICIAN:**

PLEASE ATTACH IMMUNIZATION RECORD.

Physical Examination	Results	Recommendations
Height		
Weight		
BMI		
Pulse		
BP		
Hair/Scalp		
Skin		
Eyes/Vision		
Ears Hearing		
Nose/Throat		
Teeth/Gingiva		
Lymph Glands		
Heart		
Lungs		
Abdomen		
Genitourinary		
Neuromuscular System		
Spine (Scoliosis)		
Extremities		

Clinical diagnosis:____

____

____

____

____

Present Medication (name/dose): ____

____

This student can participate in sport/outdoor activities for the current school year (check)? No_____ Yes______

Printed Physician's Name: ____

Signature of Physician **Address** **Telephone #** **Date**

Exemptions to the school laws for immunizations are:

- medical reasons;
- religious beliefs; and
- philosophical/strong moral or ethical conviction.

If your child is exempt from immunizations, he or she may be removed from school during an outbreak.

VACCINE SAFETY

- Vaccines are held to the highest standard of safety.
- The United States has the safest, most effective vaccine supply in history.
- Vaccines are continually monitored for safety and effectiveness.

Pennsylvania's school immunization requirements can be found in 28 PA Code Ch.23 (School Immunization).

Contact your health care provider or the Pennsylvania Department of Health at 1-877-PA-HEALTH (1-877-724-3258).

Vaccine information can be found at: www.dontwaitvaccinate.pa.gov

Rev. 03/17

PENNSYLVANIA SCHOOL IMMUNIZATION REQUIREMENTS

IMMUNIZE --
Don't Wait. Vaccinate.

Children in **ALL** grades (K-12) need the following **immunizations for attendance:**

- 4 doses of tetanus, diphtheria and acellular pertussis*
  (1 dose on or after 4th birthday)
- 4 doses of polio (4th dose on or after 4th birthday and at least 6 months after previous dose given)
- 2 doses of measles, mumps and rubella**
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox) or evidence of immunity

Seventh through 12th Grade ADDITIONAL immunization requirements for attendance:

- 2 doses meningococcal conjugate vaccine (MCV)
  - First dose is given 11-15 years of age; a second dose is required at age 16 or entry into 12th grade.
  - If the dose was given at 16 years of age or older, only one dose is required.
- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap)

* Usually given as DTaP or DTP or DT or Td
* * Usually given as MMR

Hill Top Preparatory School
737 South Ithan Ave, Rosemont, PA 19010
Phone 610 527 3230
Fax 610 527 7683

ADMINISTRATION of MEDICATION in SCHOOL

Authorization for the Administration of Medication by School Personnel

Administration of prescription medication in school requires a written order form from a physician/dentist and a parent signature.
Please have the medication form below completed and return it to the health office.
Medications must be in pharmacy prepared containers and labeled with the name of student, name of medication, dose, time, physician/dentist name and date of original prescription.

Date:____

Name of student:____

Medication, Dose, Time:____

____

____

Name of physician/dentist____

Phone number____

Signature of physician/dentist____
Date________________________

Authorization by parent/guardian
I authorize and request that the medication listed above be administered by school personnel.

Signature of Parent/Guardian____
Date_______________________

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

THORNCROFT EQUESTRIAN CENTER –
190 LINE ROAD, MALVERN, PA 19355
Phone: 610-644-1963/Fax: 610-644-9342

MEDICAL HISTORY

TO BE COMPLETED BY PHYSICIAN

PLEASE WRITE LEGIBLY

NAME: ______________________ DATE: ________________ PHONE: ______________

E-MAIL ADDRESS: ____________________________

ADDRESS: ____

DATE OF BIRTH: ______________ AGE: ______ SEX: ______ HEIGHT: ______ WEIGHT: ______

PARENT/GUARDIAN NAME: ____

HEALTH INSURANCE COMPANY: ________________________ POLICY NUMBER: ____________

Physically Handicapped: Yes _____ No _____ Mentally Retarded: Yes _____ No _____

Emotionally Disturbed: Yes _____ No _____ Learning Disabled: Yes _____ No _____

DIAGNOSIS: ____

Cause: ____________________________ Onset: ____________________________

Limbs Affected: ____

If Spinal Cord Injury, what vertebral level? ______________________________

If Down Syndrome, is Atlantoaxial Instability present (AAI): ____________________

If Down Syndrome Date of Cervical Spine X-ray: ____________ Age at the time of x-ray: ____________

Estimate of mental ability: ____

MOBILITY STATUS:

Can the student ambulate? Yes _____ No _____

Assistance: Independent ______ Minimal ______ Moderate ______ Maximal ______

Physical Aids: Canes ______ Crutches ______ Walker ______ Wheelchair ______ Braces ______

Please describe any other additional information that might help us to work with this student. (Medications, fears/concerns, support system, and other interests, etc.) ____

____

____

____

Please indicate if the student has any of the following secondary problems by checking yes or no. If yes, please include complete information pertaining to the problem.

Problem	Yes	No	Description (*PLEASE PRINT*)
ALLERGIES			
VISION			
HEARING			
COMMUNICATION/SPEECH			
CARDIAC Pulse: Blood Pressure:			
CIRCULARTORY Hemophilia			
PULMONARY			
METABOLIC/G.I.G.U. Diabetes, Bladder/Bowel			
SKIN & SOFT TISSUE Pressure sores			
PAST/RECENT SURGERY/SURGERIES			Date(s)
CHRONIC PAIN			
MEDICATION			
NEUROLOGICAL			
SEIZURE			Controlled: Yes/No Type: Date of Last: If No, How Often: Indications of Seizures:
BEHAVIORAL			
MUSCULAR/Contractures			
SKELETAL (A) - Subluxing Hips, Fractures			
SKELETAL (B) - Scoliosis, Kyphosis, Lordosis,			Degrees:
CONTAGIOUS CONDITION			Hepatitis _____ AIDS ____ Other:

Physician's Signature: ______________________________ **Date:** ____________

Physician's Name (Please Print): ______________________________ **Phone:** ____________

Office Name: ____________________ **Address** ______________________________

THERAPEUTIC HORSEBACK RIDING REFERRAL

PLEASE WRITE LEGIBLY AND IN DETAIL

STUDENT'S NAME: ______________________ PHONE: __________

DIAGNOSIS: ONSET:

______________________ __________
______________________ __________
______________________ __________
______________________ __________
______________________ __________
______________________ __________
______________________ __________
______________________ __________
______________________ __________

PRECAUTIONS:

____
____
____
____
____
____
____

ADDITIONAL COMMENTS:

____
____
____
____
____
____
____
____

REFERRING PHYSICIAN: ______________________ DATE: __________
Please Print 11/07