

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			
<p><i>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></p>			
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: _____	

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



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 _____

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		<input type="checkbox"/> M <input type="checkbox"/> F		

ADDRESS

No. and Street	City or Post Office	Borough or Township	County	State	Zip
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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:			
CIRCULATORY 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