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

pennsylvania
DEPARTMENT OF HEALTH

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 (Last / First / Middle)	AGE	SEX	GRADE	SECTION/ROOM
		☐ 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