Hill Top Preparatory School's health packet consists of 3 forms: Physical Examination, Administration of Medication at School, and Dental Examination. Following is an identification of the students who are required to complete each form. Please upload completed forms to Magnus.

PHYSICAL EXAMINATION FORM:

To be completed for

- NEW STUDENTS
- STUDENTS ENTERING SIXTH AND ELEVENTH GRADE
- STUDENTS WHO WILL BE PARTICIPATING IN AFTERNOON SPORTS (INCLUDING OUTDOORS CLUB)

Physician's examination forms may be substituted.

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 the 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.

DENTAL EXAMINATION FORM:

To be completed for

- NEW STUDENTS
- STUDENTS ENTERING SEVENTH GRADE

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**

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