

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

EMERGENCY MEDICAL:

ALL STUDENTS

PHYSICAL EXAMINATION FORM:

NEW STUDENTS

STUDENTS ENTERING SIXTH AND ELEVENTH GRADE

STUDENTS WHO WILL BE PARTICIPATING IN AFTERNOON SPORTS (INCLUDING OUTDOORS CLUB)

ADMINISTRATION of MEDICATION at SCHOOL FORM:

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:

STUDENTS WHO WILL PARTICIPATE AT THORNCROFT

DENTAL EXAMINATION FORM:

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				
<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>				
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**

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
----------------	---------------------	---------------------	--------	-------	-----

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

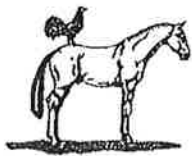
Treatment Completed Yes No

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