1. Purpose

In order to safeguard the school community from the spread of certain communicable diseases and infectious conditions; the Board requires that established policy and guidelines be followed.

2. Authority

The Board authorizes the Superintendent, in conjunction with the District’s certified school nurses, to prepare detailed administrative procedures to ensure the safety and well-being of students and staff. The purpose of this policy shall be two-fold: to safeguard the health and well-being of students and employees, and concurrently, to protect the rights of the individual.

3. Guidelines

1. All students shall be immunized against certain diseases in accordance with Pennsylvania statutes, unless specifically exempt for medical, religious or philosophical/strong moral or ethical conviction.

2. No student shall be admitted to school for the first time who has not been immunized against diseases enumerated by the Pennsylvania Department of Health, in the manner directed by the Secretary of Health.

3. Implementation of immunization requirements shall be the responsibility of the Superintendent or designee and the certified school nurse, who shall be subject to the sanctions of law for violation of the state statute for immunization.

4. A student shall be exempt from the requirements for immunization whose physician certifies that the child’s physical condition disallows immunization or whose parent or guardian objects in writing to such immunization for religious or philosophical/strong moral or ethical conviction.
The Superintendent or designee shall:

a. See that the certified school nurses annually review state standards for immunization and advise accordingly the responsible district personnel.

b. Inform parents and guardians prior to a student’s entry to school for the first time of the requirements for immunization, the requisite proof of immunization, exemptions available for medical, religious reasons and philosophical/strong moral or ethical conviction, and means by which such exemptions may be claimed.

c. Investigate and recommend to the Board district-sponsored programs of immunization as may be warranted by circumstances and the health of the school community. Any such program is subject to Superintendent approval and should be conducted in cooperation with local health agencies.

4. Health Records

The District shall require that prior to a student’s admittance to school for the first time; the parent or guardian shall complete a medical history report form that includes information regarding known communicable diseases. The nurse or school physician may use such reports to advise the parent of the need for further medical care.

The school nurse shall report the presence of suspected communicable diseases to the appropriate local health authority as required by the Department of Health.

All health records shall be confidential, and their contents shall be divulged only when necessary for the health of the student or at the written request of the parent or guardian to a physician.

As part of the health record, a certificate of immunization shall be maintained for each student enrolled, as required by the Pennsylvania Department of Health.

5. Attendance

The Board authorizes that students who have been diagnosed by a physician or who are suspected of having a disease by the school nurse shall be excluded from school for a period indicated by regulations of the Department of Health for certain specified diseases and infectious conditions.
The school physician shall make a preliminary recommendation to the District as to the health risks associated with the diagnosed communicable disease or infectious condition. In the event that potential health risks to the school community would be identified by the school physician due to the admission or continued attendance of a student in question, a panel shall be convened to review the medical history and assess the specific health risks to the identified student and to the school community.

Prior to the panel’s assessment and recommendation as to health risks, the Superintendent may exclude the child from school.

The panel shall consist of: Superintendent or designee, school physician, school nurse, principal, and a specialist in infectious diseases.

After consulting with the family physician and parent, the panel shall make an assessment of the potential for transmission of the communicable disease or infectious condition to the school community and the risks associated with potential infection. Within ten days, the panel shall make a recommendation to the Superintendent regarding the attendance of the student.

Upon receipt of the report of the panel, the Superintendent may consult with anyone who he feels can provide additional information. Within five days, the Superintendent will make a final decision regarding the attendance or placement of the student.

First consideration must be given to maintaining the infected student in a regular assignment. Any decision for an alternative placement must be supported by specific facts and data.

An infected student, who is unable to attend school, as determined by a medical examination, shall be considered for homebound instruction or an alternative placement.

An infected student may be excused from school attendance if the parent/guardian seeks such excusal based on the advice of medical or psychological experts treating the student.

An infected student’s placement shall be reassessed if there is a change in the student’s need for accommodations or services.
| 6. Education | Instruction regarding communicable and life threatening diseases shall be provided by the schools in the educational program for all levels. Parents and guardians shall be provided convenient opportunities to preview all instructional materials used in presentation of this subject. |
CONSENT TO RELEASE PERSONALLY IDENTIFIABLE INFORMATION

I/We hereby authorize the Intermediate Unit Number 20 to ___ orally or ___ in writing release the following personally identifiable information from the educational records of my son/daughter _______________________________________.

(Given and family name of student)

The release shall be to ____________________________________________________ The

(Name, position, agency/institutional affiliation.)

reason(s) for the release is ________________________________________________

_______ All information listed below

_______ Basic General Information (name, address, birthdate, telephone)

_______ Plan of Individual Education Program

_______ End of Year Progress Report/Grades

_______ Group Intelligence Results

_______ Group Achievement/Diagnostic Test Results

_______ Reevaluation Summary

_______ Report of Specific Learning Disability

_______ Psychological Report

_______ Teacher, itinerant therapist or other Intermediate Unit professional employee's written observation or ratings which are part of the educational record

_______ Other (specify)

Signature of Parent/Guardian/Eligible Student __________ Date __________
REQUEST FOR AN EDUCATION RECORD HEARING TO AMEND RECORD

TO: Dr. John A. Abbruzzese, Jr.
    Director, Special Education

I/We request a hearing to challenge the verification/validity of information contained in the education record of ___________________________ (Given and family name of student).

Specific reference is made to ___________________________ (explain briefly information in question)

________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

( )

It is understood a hearing will be scheduled within thirty calendar days upon receipt of this form by the Director of Special Education at the above address.

Signature of Parent(s), Guardian/Eligible Student

Date __________________________
WILSON AREA SCHOOL DISTRICT

Date ____________________

HEALTH INFORMATION

Child's Name ____________________ Birthdate _______ Male _______ Female _______

Parents:  Mother ____________________ Address ____________________ Phone _______

Father ____________________ Address ____________________ Phone _______

Hearing difficulties? Yes ___ No ___

Ear aches ___ Hearing aid ___ Tubes ___

Speech difficulties: Yes ___ No ___

Cleft palate ___ Hare Lip ___

Vision: Doctor ____________________

___ Glasses ___ Watering, bloodshot eyes

___ Crossed eyes ___ Sitting close to TV

___ Frequent sties ___ Red-rimmed, crusted, swollen lids

___ Burning or itching ___ Tilting head to side

___ Rubbing of eyes ___ Headaches

Is your child now receiving dental care? ___ Yes ___ No

Name of Dentist ____________________ Child's Physician ____________________

Communicable Diseases and Illness: (Give dates if known)

___ Measles ___ Heart defect

___ German Measles ___ Rheumatic Fever

___ Chicken Pox ___ Epilepsy

___ Mumps ___ Convulsions

___ Scarlet Fever ___ Pneumonia

___ Strep Throat ___ Frequent colds

___ Polio ___

___ Diabetes ___

Allergies: ___ Bee Sting ___ Asthma ___ Milk

________________________________________ Food

________________________________________ Other

Any family member have a communicable disease now? Yes ___ No ___

If so, what disease? ________________________________________________

T.B. ____________________ Child ____________________ Adult _______

AIDS or Related Syndrome ____________________ Child ____________________ Adult _______

Head Injuries:  How  ____________________________  When?  ______

Treatment:  __________________________________________

Other accidents and dates:  ____________________________

Hospitalizations:  ______________________________________

Date of last tetanus booster:  __________________________

Is your child taking any medication regularly?  Yes  ____  No  ____

Reason:  ______________________________________________

Physical:

How is your child's balance and coordination:  __________________________

Overactive:  Yes  ____  No  ____  Underactive:  Yes  ____  No  ____

Orthopedic Problems:  ______________________________________

Deformities:  __________________________________________

Restrictions because of health (specify)  ________________________

Were there any factors during your pregnancy or in the life of your child since birth that you think may have affected his development?

________________________________________________________________________

________________________________________________________________________

Child attended: (At what age)

_______ Preschool

_______ Day Care

_______ Nursery School

Any additional information you would like the school to have.

Parent or Guardian's Signature  __________________________