

Name \_\_\_\_\_

## NEW STUDENT PACKET CHECKLIST

- Student Information Sheet
- Admissions Affidavit (Provisions of ACTS 26 &30)
- EH - 40 Form
- Emergency Contact Form
- Media Release Form
- Immunization List
- Immunization Exemption Form
- Medications Form
- Report of Physical Examination
- Report of Private Dental Examinations
- Copy of Birth Certificate or Baptismal Certificate
- Final Report Card from 8th grade
- Transcripts from all previous high schools (if applicable)
- Proof of Address (at least 3 from the following: Voter's Registration, Driver's License, Copy of automobile insurance policy, non-Driver's license, Utility bill (gas, water, or electric))



Dear Parent/Guardian of our new CAPA student:

**Welcome!** Enclosed in this packet is important paperwork that requires a complete and timely response from you. It is crucial that you give careful attention to completing all the required paperwork, so all records are in place by the first day of school.

*It is understood that you may not be able to schedule a physical examination as quickly as needed, but please forward all other completed records as soon as possible, but no later than August 24, 2026.*

#### Parents/Guardians of Philadelphia Public School Students

Even though student records are forwarded to us by their present school, it is imperative that you complete our forms so that we can update your child's records accordingly.

#### Summer Reading List

Please find the enclosed Summer Reading/Assignment List. Your child is required to complete the assignment for their September 2026 grade level for the first day of school. These works will constitute the initial activities in our classes. This information is also available on our website [capa.philasd.org](http://capa.philasd.org) – navigate to the **STUDENTS** tab and you will see it in the drop-down menu to the right.

#### Sports Offered at CAPA

Fall sports begin August 15, 2026. If your child is interested, please contact the school at (215) 400-8140 and the coach will return your call with specific information. They must have completed PIAA Physicals!

#### "Welcome to CAPA" – August 17, 2026, 10-12

You will receive your child's schedule, lockers will be distributed, and Student ID cards will be created, and important information will be dispersed. Please plan to contact the school nurse (Nurse Vasile, ext. 219, [fvasile@philasd.org](mailto:fvasile@philasd.org)) if your child has any chronic medical condition and/or if they are taking medication on a regular basis. The first full day of school is Monday, August 24, 2026.

Thank you for your cooperation and your ENTHUSIASM about CAPA!

With your continued support and your child's best efforts, we look forward to making this year one of CAPA's very best ever!



In order to simplify the registration process, please complete the enclosed forms and return them to CAPA's Main Office. If you have any questions, please call Ms. Barnhill at (215) 400-8140 between 8:00 AM - 12:00 and 1:00 - 3:00 M-F.

**PLEASE NOTE: STUDENTS WILL NOT BE ADMITTED WITHOUT A COMPLETED PACKET**

**1. Student Information Sheet**

If parents are divorced, separated, etc. a copy of the Legal Decree or "Delegation of Authority" indicating the Custody Agreement in effect for your child **MUST** be included when you return this packet. Documentation is required and will be kept on file.

Anyone NOT listed on this Student Information Sheet will NOT be permitted to have access to your child, nor will we be able to release your child to them in the event of an early dismissal. For that reason, it is advisable that you include the information for any person you might need to pick up your child.

Also, please advise our secretary, in the main office if any of the information you previously submitted changes. Proof of address, as stated on page 3, line (e,) is required.

**ALL LEGAL CUSTODIAL PAPERS MUST BE RETURNED WITH THIS PACKET OF INFORMATION**

**THE STUDENT'S NAME, TO BE USED ON SCHOOL DISTRICT RECORDS, MUST APPEAR EXACTLY AS IT DOES ON THEIR BIRTH CERTIFICATE. \*\*A copy of the birth certificate must be submitted.**

**2. Admissions Affidavit (Provisions of ACTS 26 & 30)**

**3. EH-40 Form (IMPORTANT: Please indicate if your child has ever attended a Philadelphia Public School; this includes Kindergarten)**

**4. Emergency Contact Form**

**5. Media Release Form**

**6. Immunization List (contact your family doctor)**



**7. Immunization Exemption Form (If needed)**

**8. Medications Form**

**9. Report of Physical Examination**

**10. Report of Private Dental Examinations**

**Please include the following:**

- A copy of your child's BIRTH CERTIFICATE or BAPTISMAL CERTIFICATE
- Final Report Card from 8<sup>th</sup> grade
- Transcripts from all previous high schools (if applicable)
- **Proof of Address (You must produce at least 3 from the following):**  
Voter's Registration, Driver's License, Copy of automobile insurance policy, non-Driver's license, Utility bill (gas, water, or electric)



## CAPA SUMMER 2026 (for SY 26-27) READING LIST

**PARENT/GUARDIAN:** Please review the Summer Reading List and please arrange for your child to read *both* of the books required for the grade they will be entering in August 2026. **\*Please note that the instructions are different for AP Courses\***. They will be held responsible for demonstrating understanding of these readings with an essay and/or a multiple choice exam that will take place in the first month of the school year. It is critical that they read and analyze their texts before returning to school.

Additionally, *AP English* courses have a paper due on the first day of school. These assignments should be obtained *before* the end of the 2026-2027 school year. Should you need help accessing a copy, ask your English teachers before the end of the current school year.

9 <sup>th</sup> Grade	<ol style="list-style-type: none"> <li>1. <i>Felix Ever After</i> by Kacen Callender</li> <li>2. <i>The Joy Luck Club</i> by Amy Tan</li> </ol>
10 <sup>th</sup> Grade	<ol style="list-style-type: none"> <li>1. <i>Their Eyes Were Watching God</i> by Zora Neale Hurston</li> <li>2. <i>The Alchemist</i> by Paulo Coelho</li> </ol>
11 <sup>th</sup> Grade	<ol style="list-style-type: none"> <li>1. <i>If Beale Street Could Talk</i> by James Baldwin</li> <li>2. <i>Outliers: The Story of Success</i> by Malcolm Gladwell</li> </ol>
11 <sup>th</sup> Grade AP	<ol style="list-style-type: none"> <li>1. <i>Thank You for Arguing: What Aristotle, Lincoln, And Homer Simpson Can Teach Us About The Art of Persuasion</i> by Jay Heinrichs</li> <li>2. Your choice of text from a list of <u>Nonfiction titles</u></li> </ol> <p><u>See full assignment here.</u> Assignment should be completed on Google Drive and submitted through Google Classroom before the first day of class.</p>
12 <sup>th</sup> Grade	<ol style="list-style-type: none"> <li>1. <i>Handmaid's Tale</i> by Margaret Atwood</li> <li>2. Your choice of text from this list: <i>A Thousand Splendid Suns</i> by Khaled Hosseini <i>Pride and Prejudice</i> by Jane Austen <i>Beloved</i> by Toni Morrison <i>On Earth We're Briefly Gorgeous</i> by Ocean Vuong</li> </ol>
12 <sup>th</sup> Grade AP	<ol style="list-style-type: none"> <li>1. <i>How to Read Literature Like a Professor</i> by Thomas C. Foster</li> <li>2. Your choice of two texts from this list: <i>A Thousand Splendid Suns</i> by Khaled Hosseini <i>Pride and Prejudice</i> by Jane Austen <i>Beloved</i> by Toni Morrison <i>On Earth We're Briefly Gorgeous</i> by Ocean Vuong <i>Handmaid's Tale</i> by Margaret Atwood</li> </ol> <p><u>See full assignment here.</u> Assignment should be completed on Google Drive and submitted through Google Classroom before the first day of class.</p>

- You may reference the MLA Handbook for Writers of Research Papers, 8th ed. here.
- You may also access The Purdue University Online Writing Lab for general writing resources, MLA formatting and style guide at: <http://owl.english.purdue.edu/>

*Students will be expected to follow these rules in their writing at CAPA and in college.  
The summer reading list and AP summer assignments will also be available on the school's website.*

STUDENT INFORMATION SHEET

Student's

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Parent Telephone#: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Art Area: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Please indicate if it is OK to text : \_\_\_\_\_ YES \_\_\_\_\_ NO

Father's Work#: \_\_\_\_\_ Father's Cell# \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Please indicate if it is OK to text : \_\_\_\_\_ YES \_\_\_\_\_ NO

Mother's Work#: \_\_\_\_\_ Mother's Cell# \_\_\_\_\_

Parent/Guardian Email Address: \_\_\_\_\_

**If parents are divorced, separated, etc., a COPY OF THE LEGAL DECREE indicating the Custody Agreement in effect for your child MUST BE INCLUDED when you return this packet.**

Emergency Contact Name/Relationship and Phone#

\_\_\_\_\_  
\_\_\_\_\_



ADMISSIONS AFFIDAVIT  
(Provisions of ACTS 26 & 30)

I, \_\_\_\_\_, parent/guardian of student,  
\_\_\_\_\_, do hereby swear/affirm that the  
above identified student: (check one)

- 1. \_\_\_\_\_ is currently on
- 2. \_\_\_\_\_ was previously on
- 3. \_\_\_\_\_ was never on

suspension or expulsion from any public or private school in Pennsylvania or any other jurisdiction for possession or use of any weapon, drugs, alcohol or for any act of violence on school property or for any act which resulted in injury to another person.

If (1) or (2) above apply to this student, you must provide the following information:

1. The name and address of the school from which the student was suspended or expelled:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. The dates of the suspension(s) or expulsion:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. The reason(s) for the suspension(s) or expulsion:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Is your child eligible for Special Education services?

Yes \_\_\_\_\_ No \_\_\_\_\_

I make this statement with the full knowledge that any misstatement or omission make me subject to the criminal penalties of 24 P.S. §1304A relating to falsification of this document.

Signed: \_\_\_\_\_



SCHOOL DISTRICT OF PHILADELPHIA  
STUDENT REGISTRATION FORM (EH-40)

PARENT / GUARDIAN MUST COMPLETE THIS FORM AND PROVIDE ALL NECESSARY DOCUMENTS

Please Print All

**STUDENT INFORMATION - SECTION 1**

Last Name		First Name		M.I.	Date of Birth		STUDENT ID NUMBER	
					MONTH	DAY	YEAR	
House No.	Dir	Street Name			St., Ave., Etc.	Apt#	Zip Code	Phone Number

Race Designation: Is this student Hispanic  Yes or  No      Gender:  Male /  Female      Country of Birth: \_\_\_\_\_

Check all races that apply:      Home Primary Language \_\_\_\_\_

White    Black / African American       Native Hawaiian / Other Pacific Islander      Date child first enrolled into a U.S. School \_\_\_\_\_

Asian    American Indian / Alaska Native

**STUDENT ENROLLMENT HISTORY - SECTION 2**

Indicate city and type of school child last attended       Public School \_\_\_\_\_

Philadelphia       Other City: \_\_\_\_\_       Non Public School \_\_\_\_\_

Date Last Attended	Grade Last Attended	Name of School	Address	City	State

If the student attended school outside of the United States, do you have his/her school records?

Yes:      If yes, please provide a copy for the school \_\_\_\_\_

No:      If no, please contact the school to obtain the records \_\_\_\_\_

Did the child ever attend:    Pre-Kindergarten and/or  Kindergarten

1) Has the child ever received Special Education Services in PA or another state?    Yes    No      If yes, which state: \_\_\_\_\_

2) Does your child have a current IEP?       Yes    No

3) Does your child have a current evaluation report?       Yes    No      If yes, what \_\_\_\_\_

4) Was the child ever enrolled in an Early Intervention Program?       Yes    No

5) Has the child ever received ESOL/Bilingual services?       Yes    No      If yes, which state: \_\_\_\_\_

6) Does your child have a 504       Yes    No

7) Does your child have a Gifted IEP?       Yes    No

**LANGUAGE SURVEY - SECTION 3**

	English	Other	Language
1) What language does the family speak at home most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2) What language does the parent(s) speak to her/his child most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3) What language does the child speak to her / his parent(s) most of the time?*	<input type="checkbox"/>	<input type="checkbox"/>	_____
4) What language does the child speak to her/his brothers/sisters most of the time?*	<input type="checkbox"/>	<input type="checkbox"/>	_____
5) What language does the child speak to her/his friends most of the time?*	<input type="checkbox"/>	<input type="checkbox"/>	_____
6) What language does the child speak most frequently?*	<input type="checkbox"/>	<input type="checkbox"/>	_____
7) What other languages does the child speak?   1) _____ 2) _____ 3) _____			

\* If the answer to these questions is other than English, the student must be given the English placement test (W-APT) by a certified administrator.

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7a.

SCHOOL DISTRICT OF PHILADELPHIA  
STUDENT REGISTRATION FORM (EH-40)  
PARENT / GUARDIAN MUST COMPLETE THIS FORM AND PROVIDE ALL NECESSARY DOCUMENTS

HOUSEHOLD INFORMATION - SECTION 4

Student Resides With:

- Both Parents (same address)       Mother       Father       Stepparent       Guardian / Other

Parent / Guardian Name:

Parent / Guardian Name:

(Circle) Mother / Father / Stepparent / Guardian / Other \_\_\_\_\_

(Circle) Mother / Father / Stepparent / Guardian / Other \_\_\_\_\_

(Circle) Male / Female      [Active Military] Yes / No

(Circle) Male / Female      [Active Military] Yes / No

Address:

Address:

Phone:

Phone:

(Home)

(Home)

(Cell)

(Cell)

(Work)

(Work)

Email:

Email:

Preferred Language for School Related Communications:

Preferred Language for School Related Communications:

McKINNEY-VENTO ELIGIBILITY - SECTION 4 (continued) (THIS INFORMATION WILL BE KEPT CONFIDENTIAL)

Please indicate your current housing status:  Rent  Lease  Own

- In a motel/hotel due to loss of housing, economic hardship or similar reason
- Are you currently living with a family member due to loss of housing, economic hardship or similar reason
- Did you experience a man-made disaster/fire
- Did you experience an eviction

If the family is eligible for the Homeless Assistance Act of 1987 (known as McKinney-Vento) please contact your school counselor once registration is completed.

SIBLING INFORMATION - SECTION 5

Please list all school aged children (ages 5 and above)

Name	D.O.B.	Current School	Grade	Student ID# if available

EMERGENCY CONTACT INFORMATION - SECTION 6

\* Please list two LOCAL emergency contacts and their relationship to the child in the event a parent or guardian cannot be reached:

Primary

1) Name \_\_\_\_\_ Relationship \_\_\_\_\_ Gender: Male / Female

Phone (1) \_\_\_\_\_ Phone (2) \_\_\_\_\_

Secondary

2) Name \_\_\_\_\_ Relationship \_\_\_\_\_ Gender: Male / Female

Phone (1) \_\_\_\_\_ Phone (2) \_\_\_\_\_

By signing below, I am allowing the School District of Philadelphia to register my child as a student. I also certify the information provided on this application to be true and accurate and providing false or incomplete information that is required for registration may delay enrollment.

Parent / Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent / Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

OVER



# THE SCHOOL DISTRICT OF PHILADELPHIA

## 2026 - 2027 Sch Yr

Student Emergency / Medical Information

OVER →

DOUBLE SIDED →

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

School: CAPA High School Room/Sec: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home phone: \_\_\_\_\_

Mother: \_\_\_\_\_ email: \_\_\_\_\_ phone: \_\_\_\_\_

Father: \_\_\_\_\_ email: \_\_\_\_\_ phone: \_\_\_\_\_

Guardian: \_\_\_\_\_ email: \_\_\_\_\_ phone: \_\_\_\_\_

Emergency contacts (other than parents) must be local and available for contact:

Name and Relationship to child	Phone
1. _____	_____
2. _____	_____

Child's Doctor/Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance: MA \_\_\_ CHIP \_\_\_ Private \_\_\_

Insurance company name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Please circle below to give permission to the school nurse to give your child medication.

Acetaminophen (Tylenol)	Yes	No
Ibuprofen (Motrin)	Yes	No

Please CIRCLE the following if your child:

Wears: Glasses \_\_\_\_\_ Hearing aid \_\_\_\_\_

Has: Seizures \_\_\_\_\_ Diabetes \_\_\_\_\_ Asthma \_\_\_\_\_ AD/ED \_\_\_\_\_

List Allergies: Food substitution requires a new order yearly from a health care provider: \_\_\_\_\_

The emergency medical aid/or dental care, including administration of emergency medications including stock Albuterol inhalers and EpiPens, which may be necessary to preserve the life of my child or to prevent impairment of their health in the event that time does not permit obtaining my personal consent for such care. I understand that I will be contacted as soon as possible, and will assume responsibility for giving permission for on-going care.

\* Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Does your child take medication? \_\_\_ NO \_\_\_ YES (please list)

Medication	Dose	Frequency/Time	Reason

\* Parents/Guardians Please complete, sign, \*  
and date S-865 Form and Return to the School Nurse  
to be placed on file for school year 2026-2027  
Thank you, Nurse Vasilic

Your signature gives permission for emergency treatment; as well as for SDP School Nurses to administer medications you indicate on this emergency form; during school hours, on field trips and after school activities. I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.



Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Revised S-865 (06/2024)

OPTIONAL

Non-Aerosol Topical Sunscreen Use at School

Parents/guardians may choose to supply their child with non-aerosol topical sunscreen, if it is approved by the U.S. Food and Drug Administration. In order for a student to apply sunscreen during school hours, at a school-sponsored activity, or while under the supervision of school personnel, the parent/guardian must complete the attestations below.

*Parent/Guardian Attestation*

- By signing below, you confirm that you understand that the school is not responsible for ensuring that the sunscreen is applied by the student.
- By signing below, you confirm that the student has demonstrated that they are able to self-apply the sunscreen.



Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The school may cancel or restrict the possession, application, or use of a non-aerosol topical sunscreen product by a student if any of the following occurs:

- The student fails to comply with school rules concerning the possession, application, or use of the non-aerosol topical sunscreen product.
- The student shows an unwillingness or inability to safeguard the non-aerosol topical sunscreen product from access by other students.

If a school cancels or restricts the possession, application, or use of a non-aerosol topical sunscreen product by a student, the school shall provide written notice of the cancellation or restriction to the student's parent/guardian.



DEAR PARENTS/GUARDIANS:

At CAPA there are many activities and events that are covered by local and national media. In addition, we record and or video tape all performances and events.

This letter is to both inform you and request permission for your child's picture, voice, video, work and/or full name to be published on the School District and/or an individual school's website and/or be captured and published by the media. Students may be randomly interviewed by media outlets, as well.

Student images are used to promote student activities and celebrate student work and promote events and programs at CAPA. However, there are potential dangers associated with posting personally identifiable information on a website or media outlet, because global access to the Internet means that the School District cannot control who may view the website.

Accordingly, the School District will not release any information without prior written consent from you as the parent or legal guardian. Please return this form to THE MAIN OFFICE to indicate if your child's image, voice, video, work and/or full name may be used on the Internet or for media purposes. This permission will be applicable to any use of full name, picture, voice, work or video taken in the school year in which permission is given and will remain in effect until the full name, picture, video, work or voice is removed from the website or until consent is withdrawn. As parent or legal guardian, you may withdraw your consent at any time by sending a written letter, along with a new form, to the principal of your child's school. Thank you for your cooperation.

Check one of the following options:

\_\_\_\_\_ I/We GRANT permission for any photo/image, voice, video, work and/or full name of this student

\_\_\_\_\_ to be published on the school and/or School District's public Internet site, and other media outlets.

\_\_\_\_\_ I/We DO NOT GRANT permission for any photo/image, voice, video, work and/or full name of this student to be published on the school and/or School District's public Internet site and other media outlets.

In addition, I agree to release and hold harmless the School District, its School Reform Commission members and Board of Education, agents, officers, contractors, volunteers, and employees from and against any and all claims, demands, actions, complaints, suits or other forms of liability that shall arise out of or by reason of, or be caused by the use of my child's picture, voice, video and/or full name on the Internet.

Student's Name: \_\_\_\_\_

School/Office Name: \_\_\_\_\_

Print name of Parent/Legal Guardian: (print) \_\_\_\_\_

Signature of Parent/Legal Guardian: (sign) \_\_\_\_\_

Date Signed: \_\_\_\_\_



Date \_\_\_\_\_

Dear Parent or Guardian of \_\_\_\_\_

I am writing to inform you that Pennsylvania school immunization law requires all children enrolled in K-12 have up-to-date immunization records in order to attend school. According to our records, your child may not be properly immunized with the vaccines required for school attendance. Your child is missing the following vaccine(s):

- DTaP dose #1     Polio dose #1     MMR dose #1     Hep B dose #1     Tdap dose #1     MCV dose #1
- DTaP dose #2     Polio dose #2     MMR dose #2     Hep B dose #2
- DTaP dose #3     Polio dose #3     Varicella dose #1     Hep B dose #3
- DTaP dose #4     Polio dose #4     Varicella dose #2     Hep B dose #3

Therefore, the school has placed your child on **temporary enrollment status**. This means that you have **30 calendar days** to ensure your child receives the required missing vaccine(s), and to also provide the school with up-to-date immunization records showing proof of immunization. A child who is unable to provide the necessary records, medical plan or exemption will not be able to attend school at the end of the 30-day period.

\_\_\_\_\_ will **NOT** be allowed to attend school starting \_\_\_\_\_, if the required documentation showing proof of immunization is not provided. Please contact your child's doctor to obtain his/her immunization record or missing doses of vaccine.

Please take **ONE** of the following actions immediately:

Is this your situation?	Then do this:
1. Your child <b>HAS</b> received the immunizations marked above.	Send the information to the school so we can update our records.
2. Your child has <b>NOT</b> received the immunizations marked above.	Send this form, along with your child's Certificate of Immunization, to your child's doctor. If you can't get an appointment with your doctor, call (215) 685-2933 to schedule a visit to a city health center.
3. You have medical, religious, or personal reasons for not vaccinating your child.	Send a completed Immunization Exemption form to the school.

If we don't receive your information within this timeframe, the school must send you a Notice of Immunization Noncompliance. This notice will explain that your child cannot attend school until you provide the required immunization information to the school nurse.

**Where do I get more information? Where do I get forms?**

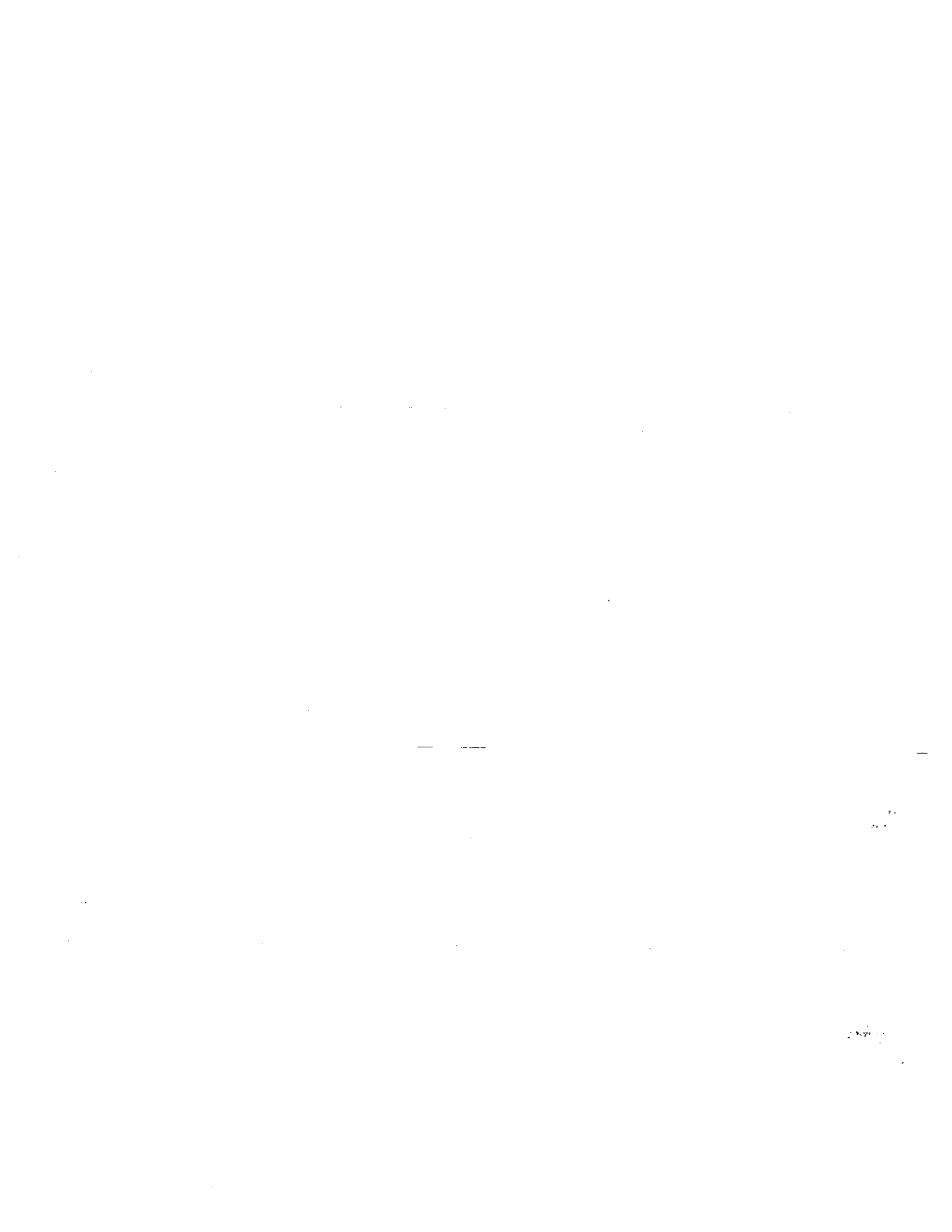
For more information about immunization requirements, including the forms mentioned above, visit

Keeping your child healthy and in school is very important. I am available to assist and address any questions or concerns you may have. I can also provide resources to help your child become immunized and obtain access to health care.

You can reach me at \_\_\_\_\_ for help or more information.

Sincerely,

Certified School Nurse



# Immunization Exemption Form

(Medical/Religious/Philosophical)

For School Immunization Requirements

2026 - 2027 Sch Yr

* Student's Full Name:		Birthdate (mm/dd/yyyy):	Grade Level:	Student ID:
Parent or Guardian's Name:		Telephone Number:		
Street Address:	City:	State:	Zip Code:	

**NOTICE:** When a health care practitioner has determined a specific vaccination is not advisable for the child for medical reasons, this form must be completed by a physician and submitted to the student's school at the start of each school year.

## Medical Exemption

Children need not be immunized if a physician or the physician's designee provides a written statement that immunization may be detrimental to the health of the child. (Please indicate which vaccine antigen(s) the medical exemption is referring to):

### Medical

- |   |  |  |                                  |
|---|--|--|----------------------------------|
| <input type="checkbox"/> Diphtheria             | <input type="checkbox"/> Tetanus       | <input type="checkbox"/> Acellular Pertussis | <input type="checkbox"/> Polio   |
| <input type="checkbox"/> Hepatitis B            | <input type="checkbox"/> Measles       | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Varicella (chickenpox) | <input type="checkbox"/> Meningococcal |  |                                  |

\* **Physician Declaration**  
I declare that the physical condition of the above-named child is such that immunization would endanger life or health.

Physician Name (print)	Physician Signature	Date
------------------------	---------------------	------

**NOTICE:** A parent or guardian may exempt their student from the vaccinations listed below by submitting this completed form to the student's school at the start of each school year.

## Personal/Philosophical or Religious Exemption

I am exempting my child from the requirement that my child be vaccinated against the following disease(s) to attend school. (Select an exemption type and the vaccinations you wish to exempt your child from):

### Personal/Philosophical

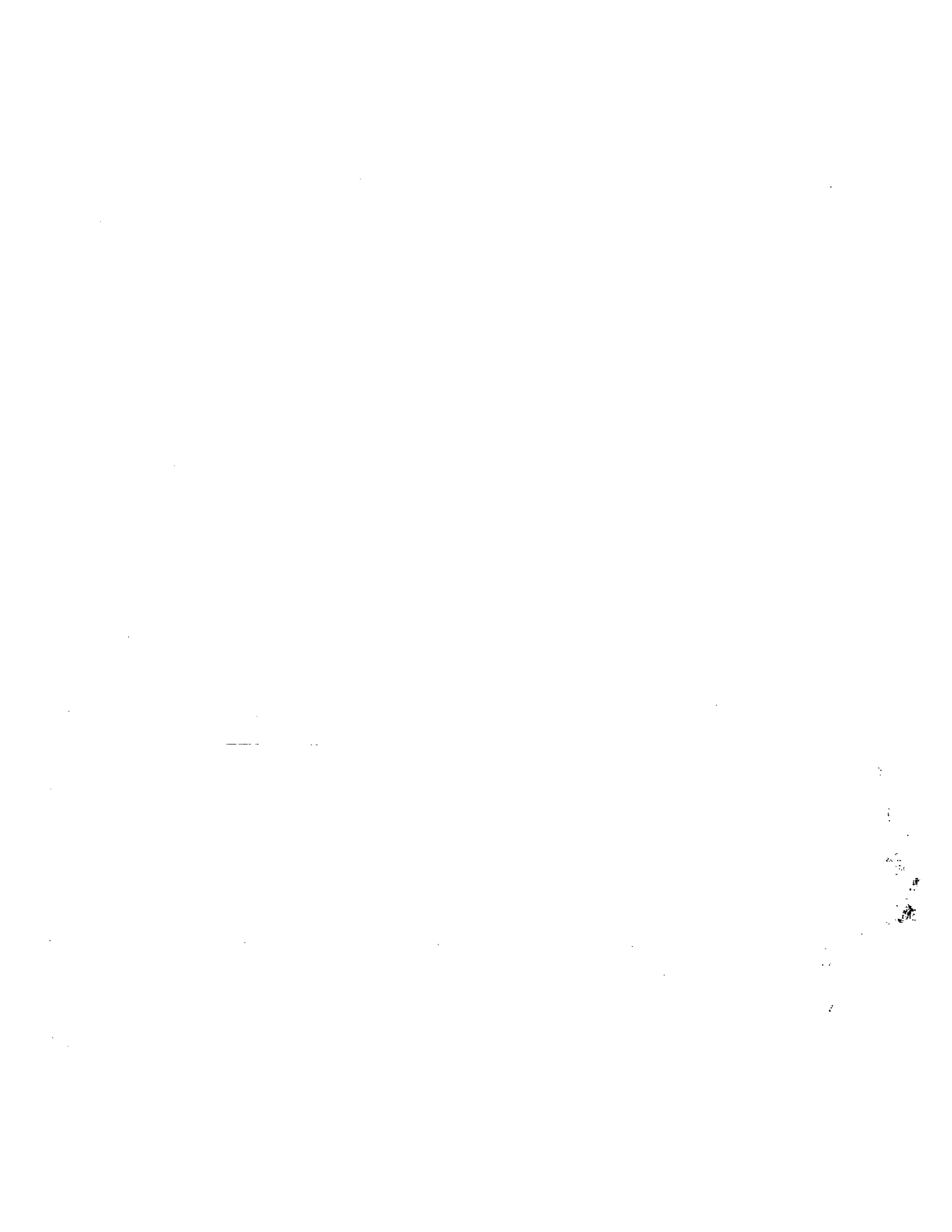
### Religious

- |   |  |  |                                  |
|---|--|--|----------------------------------|
| <input type="checkbox"/> Diphtheria             | <input type="checkbox"/> Tetanus       | <input type="checkbox"/> Acellular Pertussis | <input type="checkbox"/> Polio   |
| <input type="checkbox"/> Hepatitis B            | <input type="checkbox"/> Measles       | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Varicella (chickenpox) | <input type="checkbox"/> Meningococcal |  |                                  |

State your reason for requesting this exemption:

\* **Parent/Guardian Declaration**  
One or more of the required vaccines are in conflict with my personal, philosophical, or religious beliefs. I understand that if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school for the duration of the outbreak. I affirm that the information on this form is complete and correct.

Parent/Guardian Name (print)	Parent/Guardian Signature	Date
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Med - 1 2026 - 2027 School Year

DOUBLE SIDED  
← OVER →

← OVER →

THE SCHOOL DISTRICT OF PHILADELPHIA  
SCHOOL HEALTH SERVICES  
REQUEST FOR ADMINISTRATION OF MEDICATION

PLEASE SEE MESSAGE TO PHYSICIAN AND PARENT ON BACK OF FORM  
PHYSICIAN, PLEASE NOTE: Fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication/treatment. A separate request is needed for each medication.

NAME OF PATIENT/STUDENT	GRADE		
DATE OF BIRTH	SCHOOL	PID	
DIAGNOSIS:			
REASON MEDICATION MUST BE GIVEN IN SCHOOL:			
NAME OF MEDICATION:	DOSE:		
TIME(S) TO BE GIVEN IN SCHOOL:	TOTAL DOSE PER 24 HRS:		
DATE BEING:	DATE END:	08-31-2027	
INSTRUCTION FOR ADMINISTRATION/UTILIZATION:			
CONTRAINDICATIONS:			
SIDE EFFECTS:			
TREATMENT OF SIDE EFFECT/ACTION TO BE TAKEN:			
RESTRICTION ON ACTIVITY: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
IF YES, DESCRIBE: _____			
IS STUDENT TAKING ANY OTHER MEDICATION? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
IF YES, NAME OF MEDICATION: _____			
PRINT NAME OF HEALTH CARE PROVIDER/CREDENTIALS		TELEPHONE	
ADDRESS		EMERGENCY NUMBER	
SIGNATURE OF HEALTH CARE PROVIDER		DATE SIGNED	

I authorize licensed school personnel to administer the indicated medication as prescribed by my child's health care provider, whose signature appears on this form.

My child may self-administer medication/equipment as determined appropriate by the school nurse.

I authorize the school nurse to communicate with my child's health care provider, and my health care provider to reply, as needed regarding this medication and/or my child's response.

PARENT SIGNATURE \_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_

DATE SIGNED \_\_\_\_\_

EMERGENCY NUMBER \_\_\_\_\_

In accordance with school district procedure:

- I have assessed the student and she has demonstrated competency to self-administer medications. YES  NO
- The administration of this medication was approved on: \_\_\_\_\_

SIGNATURE OF SCHOOL NURSE

*Travis... BSN, CNA*

TELEPHONE NUMBER OF SCHOOL NURSE (215) 400-8140 option # 2

for a school nurse



Parents/Guardians please keep all medication(s), supplies, and spacers in the original package with the pharmacy label on the medication. Please note the school nurse can not accept any medication(s), supplies, etc... not in the original package. An med-1 must be completed for each prescribed medication. Thank you for your understanding!

10/20

**TO THE PHYSICIAN:**

Your patient has requested that medication be administered in school. Ideally, the administration of medication should take place at home. However, for students who require medication during the school day in order to function in the classroom, School District Policy does permit licensed school staff to administer medications. In some cases, students may self-administer their medication.

**IF YOUR PATIENT'S MEDICATION CANNOT BE ALTERED SO THAT ALL ARE RECEIVED AT HOME, PLEASE COMPLETE THE REQUEST ON THE REVERSE SIDE. A SEPARATE REQUEST IS REQUIRED FOR EACH MEDICATION OR TREATMENT.**

Please fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication/treatment.

Thank you.

School Health Services

**DEAR PARENT/GUARDIAN:**

Some children need the administration of medication in order to function in the classroom. Ideally, this should take place at home. If your child's medication cannot be altered and administered at home, you can request the medication to be given in school by seeing the school nurse.

Once the School Nurse has approved the request, you will be required to bring the medication to school properly labeled and packaged by a Registered Pharmacist. The medication bottle must have Saf-T Closure Cap and the label must include:

- Patient Name
- Pharmacy Name
- Pharmacy Address and Phone #
- Prescription Number
- Prescription Date (current)
- Name of medication, dosage form, expiration date (if relevant)
- Instructions for administration
- Name of prescribing health care provider

This procedure must be repeated each school year and/or each time there is a change in dosage.

Parents/guardians must pick up unused or expired medication in person, or send an authorized responsible adult with a note from you. Unused medication which is not picked up within 10 days, or by the last day of school, will be destroyed/discarded. ~~NO REFILLS WILL BE GIVEN FOR THIS MEDICATION. ALL MEDICATIONS MUST BE PICKED UP BY THE PATENT/GUARDIAN WITHIN 10 DAYS OF THE LAST DAY OF SCHOOL.~~

If you have any questions on this procedure, please contact the school nurse.

Thank you.

REPORT OF PHYSICAL EXAMINATION

4 SIDED

Date Issued: [Date]	Student ID#:
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Name of Student:	Date of Birth:	Grade:
Name of School: <b>CAPA HS</b>	Room/Section/Book	

TO THE PARENT/GUARDIAN:  
 I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.  
 Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

TO THE CARE PROVIDER (Please complete all items)  
 Pennsylvania law requires that students attending school in the state be immunized and receive periodic medical examinations. Payment for these examinations is the responsibility of the parent/guardian. THESE IMMUNIZATIONS ARE REQUIRED FOR SCHOOL ATTENDANCE.

RECORD OF VACCINE ADMINISTRATION

(Please attach complete immunization record including serology results if available)

Allergies \_\_\_\_\_ Date of last PPD \_\_\_\_\_ Result \_\_\_\_\_ mm

Does this student have health insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ Name of Insurance Provider: \_\_\_\_\_

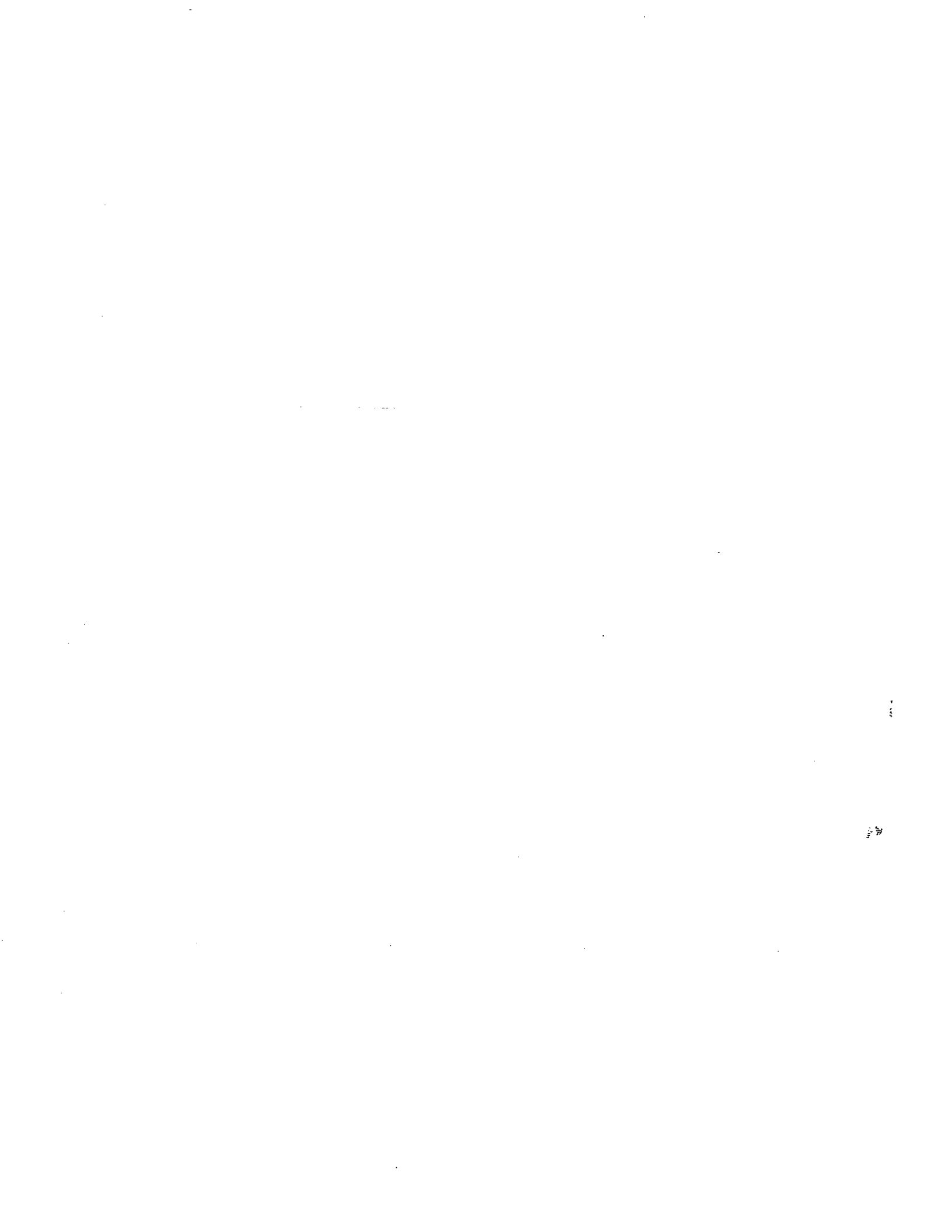
RECORD OF THE FOLLOWING

1. Visual Acuity: Without Glasses: R _____ L _____ With Glasses: R _____ L _____																				
2. Audiometric Screening: R _____ L _____ B. BP _____																				
4. Height _____ Inches/cm Weight _____ lb./kg BMI percentile _____																				
5. Scoliosis Screening: _____ Normal _____ Abnormal _____ Referred _____ No Referral																				
6. Activity Recommendation: _____ Full Physical Activity _____ Restricted Physical Activity (Must Complete Phys. E. Medical Exemption/Program Modification Form MEH-23) Specify Restrictions: _____																				
7. List all medications currently being taken: Medications: _____ Reason: _____																				
8. List ALL problems by history or examination: <table style="width:100%"> <tr> <td></td> <td>Under Care</td> <td>Care Complete</td> <td>Referred</td> </tr> <tr> <td>1. _____</td> <td>Under Care</td> <td>Care Complete</td> <td>Referred</td> </tr> <tr> <td>2. _____</td> <td>Under Care</td> <td>Care Complete</td> <td>Referred</td> </tr> <tr> <td>3. _____</td> <td>Under Care</td> <td>Care Complete</td> <td>Referred</td> </tr> <tr> <td colspan="4">_____ No Problems Identified</td> </tr> </table>		Under Care	Care Complete	Referred	1. _____	Under Care	Care Complete	Referred	2. _____	Under Care	Care Complete	Referred	3. _____	Under Care	Care Complete	Referred	_____ No Problems Identified			
	Under Care	Care Complete	Referred																	
1. _____	Under Care	Care Complete	Referred																	
2. _____	Under Care	Care Complete	Referred																	
3. _____	Under Care	Care Complete	Referred																	
_____ No Problems Identified																				

Comments/follow-up treatment plan / Special instructions to school:

Signature of Care Provider (REQUIRED)	Telephone	Care Provider office stamp (REQUIRED)
	Fax	
Address	Date of Exam	

\* Please return Physical Examination Report to the School Nurse  
 Thank you,  
 Nurse Vasil



REPORT OF PRIVATE DENTAL EXAMINATION

Name of School <b>CAPA HIGH SCHOOL</b>	Student ID	Date Issued	
Name of Student	Date of Birth	Room/Section/Book	Grade

**TO THE DENTIST**

Pennsylvania law requires that students attending school in the Commonwealth receive periodic dental examinations at stated intervals (upon original entry, while in third grade, and while in seventh grade).

These examinations are required for school attendance. Payment for these examinations is the responsibility of the parent/guardian. If the student/family does not have health insurance the school nurse will help the family apply for health insurance. Please attach a copy of the student's dental examination or record the data below.

Thank you for your cooperation.

<b>UNDER TREATMENT / WORK BEGUN</b>	<b>COMPLETION OF WORK / NO TREATMENT NECESSARY</b>
Date Work Begun	<input type="checkbox"/> No Treatment Required Now
Scheduled Follow-up Appointment	<input type="checkbox"/> All Necessary Dental Work Completed
Date of Dental Examination	Expected Completion Date

Comments / Follow-up Treatment / Special Instructions to School

Name of Dentist	Telephone
Signature of Dentist	Date Signed
Address	Fax Number

IMPORTANT:

Return this form to

Theresa Vasile BS, RN, BSN, CSN  
 Certified School Nurse/Practitioner  
The Creative and Performing Arts High School  
 School  
901 S. Broad St. Phila., PA 19147  
 School Address  
(215) 400 - 8140 option # 2 for school nurse  
 Phone Number

\* Please make a copy for your own records and then  
 Please Return Completed Dental Form to the School Nurse  
 Thank you ↓

