Corpus Christi Catholic School
SCHOOL HEALTH SERVICES
HEALTH HISTORY REVIEW

This request for information is being made to help the School Nurses update your child's School Health Record. Please circle any condition that pertains to your child, giving any additional information you believe to be significant under "COMMENTS" and return to your school nurse.

STUDENT'S NAME_____GRADE/ROOM_____

1. Allergy (list)
2. Arthritis/Rheumatic Disease
3. Asthma (medication)
4. ADD/ADHD (medication)
5. Birth/Developmental Defects
6. Bleeding Disorders/Anemia
7. Cardiovascular Conditions
8. Connective Tissue Disorders
9. Cystic Fibrosis
10. Diabetes
11. Eating Disorders
12. Endocrine Disorders
13. Gastrointestinal Disorders
14. Genitourinary Disorders
15. Hearing
16. Hypertension
17. Immunity Suppression
18. Cancer
19. Neurologic Disorders
20. Orthopedic Disorders
21. Psychiatric Disorders
22. Seizure Disorders
23. Sickle Cell Disease
24. Vision/Color Defect
25. Weight Disorders
26. Other_____

COMMENTS_____
_____

During this past year, has your child: **CIRCLE ONE**
Had an illness, serious injury or operation? (If yes, please describe) Yes No
_____

Does your child require a special diet? Yes No
If yes, please specify_____

Does your child have any allergies (food/insect/bee sting) that require medication or Epipen at school?
Please specify_____Yes No

Is your child presently taking medication? Yes No
Name of medication_____Dosage_____
Time of Day_____Reason_____
**If medication is taken at school, please provide nurse with doctor's order and the medication.

Have there been changes in your family status or any other situations that may affect your child?
_____ Yes No If yes, please explain or call to request a conference with school counselor_____
Student's Doctor_____ **Phone number**_____
Student's Dentist _____ **Phone number**_____

If you are in need of health insurance coverage and are interested in Pennsylvania's Children's Health Insurance Program (CHIP) contact your school nurse.

_____ _____

Signature of Parent/Guardian Date

Corpus Christi Catholic School
SERVICIOS DE SALUD ESCOLAR
REVISION DE LA HISTORIA DE SALUD

Esta solicitud de información se hace para ayudar a las Enfermeras de la Escuela a actualizar el Expediente de Salud Escolar de su hijo. Por favor circule cualquier información que se relacione con su hijo, dando cualquier otra información adicional que considere importante bajo "COMENTARIOS" y devuelva a la enfermera de su escuela.

NOMBRE DEL ESTUDIANTE_____GRADO/SALON_____

1. Alergia (lista)
2. Artritis/Enfermedad Reumática
3. Asma (medicamento)
4. ADD/ADHD (medication)
5. Defectos de Nacimiento/Desarrollo
6. Trastornos de Sangrado/Anemia
7. Condición Cardiovascular
8. Trastorno del Tejido Conectivo
9. Fibrosis Cística
10. Diabetes
11. Trastornos de Alimentación
12. Trastonos Endocrinos
13. Trastornos Gastrointestinales
14. Trastornos Genitourinarios
15. Oído
16. Hipertensión
17. Supresión Inmunológica
18. Cáncer
19. Trastornos Neurológicoa
20. Trastornos Ortopédicos
21. Trastornos Psiquiátricos
22. Trastornos Convulsivos
23. Enfermedad de la Celula Falciforme
24. Visión/Defecto del Color
25. Trastornos de Peso
26. Otro_____

COMENTARIOS_____
_____

Durante el año pasado, su hijo: **CIRCULE UNO**
¿Tuvo una enfermedad, lesión grave u operación? (Si es sí, por favor describa) Sí No
_____

¿Necesita su hijo una dieta especial? Sí No
Si es sí, por favor especifique_____

¿Tiene su hijo alguna alergia (comida/insecto/picadura de abeja) que necesite medicamento o Epipen en la escuela? Por favor especifique _____ Sí No

¿Está su hijo actualmente tomando medicina? Sí No
Nombre de la medicina_____Dosis_____
Hora de Día_____ Razón_____
**Si la medicina se toma en la escuela, por favor proporcione a la enfermera la orden del médico y el medicamento.

¿Ha habido cambios en su situación familiar o alguna otra situación que pueda afectar a su hijo?
_____ Sí No
Sí es sí, por favor explique o llame para solicitar una conferencia con la consejera de la escuela _____

Médico del Estudiante_____ **Número de teléfono**_____
Dentista del Estudiante _____ **Número de teléfono**_____

Si necesita cobertura de seguro de salud y está interesado en el Programa de Seguro Médico para Niños (CHIP) comuníquese con la enfermera de la escuela.

_____ _____
Firma del Padre/Encargado Fecha

CORPUS CHRISTI CATHOLIC SCHOOL
SCHOOL HEALTH SERVICES
MANDATED DENTAL EXAMINATION
FOR GRADES K/Original entry, 3 AND 7.

Re: Mandated Dental Form

For: _____ Grade:_____

The Pennsylvania Department of Health requires that every child entering school for the first time (kindergarten/original entry) and grades 3 and 7 have a dental examination. Because of your dentist's knowledge of your child's dental history, we recommend that your dentist do your child's exam. **If your child is examined by your family dentist, please have the dentist fill out the attached form and return to the school nurse.**

If you prefer, your child may receive a dental exam by the school dental hygienist at no cost to your family. The school dental exams are scheduled from November through May. Contact Melinda Ocker, RDH, PHDHP at 717-729-4759 for questions regarding the no cost dental exam.

Please check your dental screening preference below, sign and return to school nurse

I want my child to get a dental examination from the school dental hygienist.
Check one: Yes _____ No _____ (Checking yes and signing below gives your permission for the school dental hygienist to perform the mandated dental exams in all required grades - kindergarten, 3rd and 7th for which there is no private dental exam report on file. This permission may be revoked at any time by sending a signed note to the school nurse stating that you no longer desire the school dental professional to perform the exams.)

OR

I request the dental exam be done by my family dentist and have an appointment scheduled for _____(date). I have detached and will return the family dentist report with my dentist's signature to the school nurse.

Parent/Guardian signature _____ Date: _____

----------**detach and return if private dentist doing exam**----------

CORPUS CHRISTI CATHOLIC SCHOOL
Family Dentist Report

Name_____ Birthdate_____ Grade_____
Last First MI

The above named child last visited my office on_____ (DATE).

Currently, all necessary dental corrections have been made. Yes_____ No_____

If the answer is **NO**, fill in the following:

This child is in need of treatment for one or more of the following: Fillings_____ Extractions_____

Other/comments_____

This child is currently under treatment. Yes_____ No _____

Date submitted_____ **Dentist's signature**_____
Office address:

CORPUS CHRISTI CATHOLIC SCHOOL
SERVICIOS DE SALUD DE LA ESCUELA
EXAMEN DENTAL OBLIGATORIO
PARA GRADOS KINDER/ENTRADA ORIGINAL, 3 Y 7

Referente: **Forma de examen Dental Obligatorio**

Para: _____ Grado: _____

El Departamento de Salud de Pensilvania requiere que todo niño(a) que entra a la escuela por primera vez (Kínder/entrada original) y grados 3 y 7 tengan un examen dental. Debido al conocimiento que tiene el doctor del historial dental de su hijo(a), nosotros recomendamos que su dentista haga el examen de su hijo(a). **Si su hijo(a) es examinado por el dentista de la familia, por favor pida al dentista que llene la forma adjunta y la devuelva a la enfermera de la escuela para.**

Si usted prefiere, su hijo(a) puede recibir examen dental por la higienista dental de la escuela sin costo para la familia. Los exámenes de la escuela son programados desde noviembre hasta mayo. Póngase en contacto con Melinda Ocker, RDH, PHDHP en el 717-729-4759 para preguntas sobre el examen dental sin costo.

Por favor marque su preferencia de la evaluación dental abajo, firme y devuelva a la enfermera de la escuela

Yo quiero que mi hijo(a) tenga el examen dental por la higienista dental de la escuela.
Marque uno: Sí _____ No _____ Marcando sí y firmando abajo da su permiso para que la higienista haga el examen dental obligatorio en todo los grados requeridos-Kínder, 3ro 7mo en los cuales no hay un reporte en el archivo de un examen privado. Este permiso podrá ser revocado en cualquier momento mediante el envío de una nota firmada a la enfermera de la escuela que indique que usted ya no desea que la profesional dental de la escuela realice los exámenes.)

Ò

Yo solicito que el examen dental sea hecho por mi dentista de la familia y yo tengo una cita programada para el _____ (fecha). Yo he separado la parte adjunta y regresaré el informe del dentista de la familia con la firma la enfermera de la escuela.

La firma del Padre/Madre /Encargado _____ Fecha: _____

---------- **pare y devuelva si el dentista privado hace el examen** ----------

CORPUS CHRISTI CATHOLIC SCHOOL

Family Dentist Report

Name_____ **Birthdate**_____ **Grade**_____
Last **First** **MI**

The above named child last visited my office on_____ **(DATE)**_____

Currently, all necessary dental corrections have been made. Yes_____ No_____

If the answer is **NO**, fill in the following:

This child is in need of treatment for one or more of the following: Fillings_____ Extractions_____

Other/comments_____

This child is currently under treatment. Yes_____ No _____

Date submitted _____ **Dentist's signature**_____

Office address:

SCHOOL VACCINATION INFORMATION FOR PARENTS

The Department of Health is changing school immunization regulations beginning in August 2017. The regulations are intended to ensure that children attending school in the commonwealth are adequately protected against potential outbreaks of vaccine preventable diseases.

A CHILD MUST HAVE REQUIRED VACCINES OR RISK EXCLUSION FROM SCHOOL.

A child must have the required medically-appropriate vaccines or a plan to complete those vaccines or risk exclusion from school. A child may still obtain medical, religious or philosophical exemption from meeting the immunization requirements. Talk to your child's pediatrician about the vaccines your child needs to attend school.

NEW VACCINATION REQUIREMENTS:

- combination form for diphtheria and tetanus;
- pertussis vaccination;
- combination form for measles, mumps and rubella; and
- meningococcal conjugate vaccine for entry into 12th grade, or in an ungraded school, in the school year the child turns 18.

For more information on the vaccines your child needs to attend school, visit dontwaitvaccinate.pa.gov or talk to your child's pediatrician.

dontwaitvaccinate.pa.gov

pennsylvania
DEPARTMENT OF HEALTH

INFORMACIÓN PARA PADRES SOBRE VACUNACIÓN ESCOLAR

El Departamento de Salud está cambiando las normas de vacunación escolar a partir de agosto de 2017. El objetivo de estas normas es garantizar que los niños que asisten a escuelas en el estado estén protegidos adecuadamente contra potenciales brotes de enfermedades prevenibles con vacunas.

LOS NIÑOS DEBEN TENER LAS VACUNAS OBLIGATORIAS O CORREN EL RIESGO DE SER EXCLUIDOS DE LA ESCUELA.

Los niños deben tener todas las vacunas obligatorias apropiadas desde el punto de vista médico o un plan para completar las vacunas faltantes, o corren el riesgo de ser excluidos de la escuela. Los niños pueden obtener exenciones médicas, religiosas o filosóficas de los requisitos de vacunación. Hable con el pediatra de su hijo sobre las vacunas que su hijo necesita para asistir a la escuela.

NUEVOS REQUISITOS DE VACUNACIÓN:

- combinación contra la difteria y el tétanos;
- vacunación contra la tos ferina;
- combinación contra sarampión, paperas y rubéola y
- vacuna antimeningocócica conjugada para el ingreso a 12° grado o, en escuelas sin grados, al año escolar en el que el niño cumple 18 años.

Para obtener más información acerca de las vacunas que su hijo necesita para asistir a la escuela, visite dontwaitvaccinate.pa.gov o hable con el pediatra de su hijo.

dontwaitvaccinate.pa.gov

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SCHOOL VACCINATION REQUIREMENTS
FOR ATTENDANCE IN PENNSYLVANIA SCHOOLS

FOR ATTENDANCE IN ALL GRADES CHILDREN NEED THE FOLLOWING:

- 4 doses of tetanus, diphtheria, and acellular pertussis* (1 dose on or after the 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, rubella***
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox) or evidence of immunity

**Usually given as DTP or DTaP or if medically advisable, DT or Td*
*** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose*
****Usually given as MMR*

ON THE FIRST DAY OF SCHOOL, unless the child has a medical or religious/philosophical exemption, a child must have had at least one dose of the above vaccinations or risk exclusion.

- If a child does not have all the doses listed above, needs additional doses, and the next dose is medically appropriate, the child must receive that dose within the first five days of school or risk exclusion. If the next dose is not the final dose of the series, the child must also provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.
- If a child does not have all the doses listed above, needs additional doses, and the next dose is not medically appropriate, the child must provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.
- The medical plan must be followed or risk exclusion.

FOR ATTENDANCE IN 7TH GRADE:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) on the first day of 7th grade.
- 1 dose of meningococcal conjugate vaccine (MCV) on the first day of 7th grade.

ON THE FIRST DAY OF 7TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

FOR ATTENDANCE IN 12TH GRADE:

- 1 dose of MCV on the first day of 12th grade. If one dose was given at 16 years of age or older, that shall count as the twelfth grade dose.

ON THE FIRST DAY OF 12TH GRADE, unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

The vaccines required for entrance, 7th grade and 12th grade continue to be required in each succeeding school year.

These requirements allow for the following exemptions: medical reason, religious belief, or philosophical/strong moral or ethical conviction. Even if your child is exempt from immunizations, he or she may be excluded from school during an outbreak of vaccine preventable disease.

Pennsylvania's school immunization requirements can be found in 28 Pa.CODE CH.23 (School Immunization). Contact your healthcare provider or call 1-877-PA-HEALTH for more information.

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REQUISITOS DE VACUNACIÓN ESCOLAR
PARA ASISTIR A LAS ESCUELAS DE PENSILVANIA

PARA ASISTIR A TODOS LOS GRADOS, LOS NIÑOS NECESITAN LAS SIGUIENTES VACUNAS:

- 4 dosis de la vacuna contra el tétanos, la difteria y la tos ferina acelular* (1 dosis a partir de cumplir los 4 años)
- 4 dosis de la vacuna antipoliomielítica (4ta dosis a partir de cumplir los 4 años y, al menos, 6 meses después de la dosis anterior)**
- 2 dosis de la vacuna contra el sarampión, las paperas y la rubéola***
- 3 dosis de la vacuna contra la hepatitis B
- 2 dosis de la vacuna contra la varicela o evidencia de inmunidad

** Por lo general, se aplica como DTP o DTaP o, si es recomendable desde el punto de vista médico, como DT o Td.*

*** No es necesaria una cuarta dosis si la tercera dosis se administró a partir de los 4 años de edad y, al menos, 6 meses después de la dosis anterior.*

**** Por lo general, se aplica como MMR.*

EL PRIMER DÍA DE ESCUELA, a menos que el niño tenga una exención médica, religiosa o filosófica, debe haber recibido, al menos, una dosis de las vacunas antes mencionadas o corre el riesgo de ser excluido de la escuela.

• Si el niño no tiene todas las dosis antes mencionadas, si necesita dosis adicionales y la siguiente dosis es apropiada desde el punto de vista médico, debe recibir dichas dosis en el transcurso de los primeros cinco días de clases o corre el riesgo de ser excluido de la escuela. Si la siguiente dosis no es la dosis final del esquema, debe presentar también un plan médico (tarjeta roja y blanca), en el transcurso de los primeros cinco días de clases, para recibir las vacunas obligatorias o corre el riesgo de ser excluido de la escuela.

• Si el niño no tiene todas las dosis antes mencionada, si necesita dosis adicionales y la siguiente dosis no es apropiada desde el punto de vista médico, debe presentar un plan médico (tarjeta roja y blanca), en el transcurso de los primeros cinco días de clases, para recibir las vacunas obligatorias o corre el riesgo de ser excluido de la escuela.

• Se debe cumplir con el plan médico o el niño corre el riesgo de ser excluido de la escuela.

PARA ASISTIR A 7° GRADO:

• 1 dosis de la vacuna contra el tétanos, la difteria y la tos ferina acelular (Tdap) el primer día de 7° grado.
• 1 dosis de la vacuna antimeningocócica conjugada (MCV) el primer día de 7° grado.

EL PRIMER DÍA DE 7° GRADO, a menos que el niño tenga una exención médica, religiosa o filosófica, debe haber recibido las vacunas antes mencionadas o corre el riesgo de ser excluido de la escuela.

PARA ASISTIR A 12° GRADO:

• 1 dosis de MCV el primer día de 12° grado. Si se administró una dosis a partir de los 16 años de edad, dicha dosis será considerada como la dosis de 12° grado.

EL PRIMER DÍA DE 12° GRADO, a menos que el niño tenga una exención médica, religiosa o filosófica, debe haber recibido las vacunas antes mencionadas o corre el riesgo de ser excluido de la escuela.

Las vacunas obligatorias para el ingreso escolar, 7° grado y 12° grado siguen siendo obligatorias cada año escolar posterior.

Estos requisitos permiten las siguientes exenciones: motivos médicos, creencia religiosa o firme convicción filosófica, moral o ética. Incluso si su hijo está exento de la vacunación, podría ser excluido de la escuela durante un brote de una enfermedad evitable mediante vacunas.

Código de Pensilvania n.° 28, capítulo 23 (Vacunación escolar).
Comuníquese con su proveedor de atención médica o llame al 1-877-PA-HEALTH para obtener más información.

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Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date_____

Date of birth _____ Age at time of exam_____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: ***Has the student…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: ***Has the student…***	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: ***Has the student...***	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **DURING** or **AFTER** exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: ***Has the student...***	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: ***Has the student…***	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: ***Has the student…***	**YES**	**NO**
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student…***	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student_____ Date_____

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	**CHECK ONE**			***ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS**
	NORMAL	***ABNORMAL**	**DEFER**	
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	**DATE APPLIED**	**DATE READ**	**RESULT/FOLLOW-UP**

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____

Print name of examiner _____

Print examiner's office address_____ **Phone**_____

Signature of examiner_____ **MD ☐ DO ☐ PAC ☐ CRNP ☐**

STUDENT NAME:

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)
STUDENT NAME: