To be completed by licensed healthcare provider:
Physician (MD or DO), Clinical Nurse Specialist (APN), Advanced Practice Nurse (APN), or Physician’s Assistant (PA)

To Parent or Guardian:
In order to provide the best educational experience, school personnel must understand your child’s health needs. This form requests information from you (Part I) and your health care provider (Parts I, II and III). All students in Delaware public schools must provide documentation of current immunizations. Beginning in August 2016, students entering Grade 9 must have had an adolescent booster dose of Tdap and one dose of meningococcal vaccine. Additionally, a current (within 2 years) health examination is required upon school entry and prior to Grade 9.

**Talk with your health care provider about important issues** regarding your child, such as:

- **Physical Growth and Development** (physical and oral health; body image; healthy eating; physical activity)
- **Social and Academic Competence** (connectedness with family, peers, school, and community; interpersonal relationships; school performance)
- **Emotional Well-Being** (coping; mood regulation and mental health; self-esteem; sexuality)
- **Risk Reduction & Safety** (tobacco; alcohol or other drugs; pregnancy; STIs; infection; disaster planning)
- **Violence & Injury Prevention** (safety belt and helmet use; substance abuse and riding in a vehicle; abuse protection; guns; interpersonal violence [fights/dating violence]; bullying)
- **Immunizations**

### Immunizations Required for Newly Enrolled Students at Delaware Schools

**GRADES 7-12:**

- **DTaP/DTP, Td/Tdap**: Completion of the primary series plus an adolescent booster dose of Tdap administered at age 11-12 or prior to entry into Grade 9.
- **Polio**: 3 or more doses. If the 3rd dose was prior to the 4th birthday, a 4th dose is required.
- **MMR**: 2 doses. The 1st dose should be given on or after the 1st birthday. The 2nd dose should be given after the 4th birthday.
- **Hep B**: 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.
- **Varicella**: 2 doses. The 1st dose must be given on or after the 1st birthday.
- **Meningococcal**: 1 dose is required for entry into Grade 9. A second dose is recommended by the Division of Public Health for all adolescents.

### Immunizations Strongly Recommended by the Delaware Division of Public Health

- **Influenza (seasonal) vaccine**: each year for all children (6 months and up).
- **Human papillomavirus vaccine (HPV)**: all girls and boys (ages 11 or 12)
- **Pneumococcal vaccine (PCV13)**: children with specific risk factors
- **Pneumococcal vaccine (PPSV)**: certain high risk groups
- **Hepatitis A**: unvaccinated children who are or will be at increased risk

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1 Clinicians refer to: Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, (3rd Ed.) AAP, 2008
2 Disease histories for measles, rubella, mumps and Hepatitis B will not be accepted unless serologically confirmed.
3 Varicella disease history must be verified by a health care provider to be exempted from vaccination.
4 A new school enterer is a child entering a Delaware school district for the first time.
# PART I – HEALTH HISTORY

*To be completed by parent/guardian prior to exam*

*The healthcare provider should review and provide comments in the last column.*

<table>
<thead>
<tr>
<th></th>
<th>PARENT</th>
<th>HEALTHCARE PROVIDER COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental delay (speech, ambulation, other)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Serious injury or illness?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When?</td>
<td></td>
<td>What for?</td>
</tr>
<tr>
<td>Surgery? (List all)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When?</td>
<td></td>
<td>What for?</td>
</tr>
<tr>
<td>Ear/Hearing problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart problems/Shortness of breath?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Heart murmur/High blood pressure?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dizziness or chest pain with exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Allergies (food, insect, other)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Family history of sudden death before age 50?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Child wakes during the night coughing?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diagnosis of asthma?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Blood disorders (hemophilia, sickle cell, other)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Excessive weight gain or loss?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diabetes?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Loss of function of one or paired organs (eye, ear, kidney, testicle)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Head injuries/Concussion/Passed out?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Muscle, Bone, or Joint problem/Injury/Scoliosis?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>ADHD/ADD?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Behavior concerns?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Eye/Vision concerns?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Glasses</td>
<td>Contacts</td>
<td></td>
</tr>
<tr>
<td>Other_________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental concerns?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Braces</td>
<td>Bridge</td>
<td>Plate</td>
</tr>
<tr>
<td>Date of exam______________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other diagnoses?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does your child have health insurance?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does your child have dental insurance</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Information may be shared with appropriate personnel for health and educational purposes.

**Parent/Guardian**

**Signature**

**Date**

November 2016
PART II IMMUNIZATIONS

Entire section below to be completed by MD/DO/APN/NP/PA
Printed VAR form may be attached in lieu of completion.

Immunizations – Shaded Vaccines Required. Regulation is located at Title 14 Section 804: Immunizations

- DTaP/DT
- OPV/IPV
- PCV7/PCV13
- Hib
- MMR
- VAR
- PCV7/PCV13
- Hib
- PCV7/PCV13
- Hib
- PCV7/PCV13
- HepB
- MCV4
- Hep A
- Influenza
- Other:
- DTaP/DT
- OPV/IPV
- PCV7/PCV13
- Hib
- MMR
- VAR
- PCV7/PCV13
- Hib
- PCV7/PCV13
- Hib
- PCV7/PCV13
- HepB
- MCV4
- Hep A
- Influenza
- Other:
- DTaP/DT
- OPV/IPV
- PCV7/PCV13
- Hib
- MMR
- VAR
- PCV7/PCV13
- Hib
- PCV7/PCV13
- Hib
- PCV7/PCV13
- HepB
- MCV4
- Hep A
- Influenza
- Other:
- DTaP/DT
- OPV/IPV
- PCV7/PCV13
- Hib
- MMR
- VAR
- PCV7/PCV13
- Hib
- PCV7/PCV13
- Hib
- PCV7/PCV13
- HepB
- MCV4
- Hep A
- Influenza
- Other:
- DTaP/DT
- OPV/IPV
- PCV7/PCV13
- Hib
- MMR
- VAR
- PCV7/PCV13
- Hib
- PCV7/PCV13
- Hib
- PCV7/PCV13
- HepB
- MCV4
- Hep A
- Influenza
- Other:

Child is fully immunized per DPH/CDC recommendations (refer to cover page)  □ Yes  □ No

PART III – SCREENING & TESTING

Entire section below to be completed by MD/DO/APN/NP/PA

<table>
<thead>
<tr>
<th>Screen</th>
<th>Height: ________</th>
<th>Weight: ________</th>
<th>BMI: ________</th>
<th>BMI Percentile: ________</th>
<th>BP: ________</th>
<th>Pulse: ________</th>
<th>Other: ________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(inches)</td>
<td>(pounds)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

□ Problem Identified: Referred for treatment
□ No Problem: Referred for prevention
□ No Referral: Already receiving dental care

Tuberculosis Screen

All new enterers must have TB test or TB Risk Assessment, which must be done within 12 months prior to school entry.

Risk Assessment: Date_________ Results: □ Test Required □ Test Not Required

Mantoux Skin Test: Date_________ Results: ____________ MM

Other: (type)_______________ Date_________ Results: ____________ MM

Other Screen

Hearing: Type:___________ Date:_________ Results:___________ Referral: □ No  □ Yes ________ Date

Vision: Type:___________ Date:_________ Results:___________ Referral: □ No  □ Yes ________ Date

Other: Type:___________ Date:_________ Results:___________ Referral: □ No  □ Yes ________ Date
## PART IV – COMPREHENSIVE EXAM

*Entire section below to be completed by MD/DO/APN/PA*

<table>
<thead>
<tr>
<th>PHYSICAL EXAMINATION</th>
<th>Check (√)</th>
<th>HEALTHCARE PROVIDER COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NORMAL</td>
<td>ABNORMAL</td>
</tr>
<tr>
<td>General Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td></td>
<td></td>
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<tr>
<td>Nose/Throat</td>
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<td></td>
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<tr>
<td>Mouth/Dental</td>
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<tr>
<td>Cardiovascular</td>
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<tr>
<td>Musculoskeletal</td>
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<tr>
<td>Spinal examination</td>
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<tr>
<td>Nutritional status</td>
<td></td>
<td></td>
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<tr>
<td>Mental health status</td>
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<td></td>
</tr>
</tbody>
</table>

### FOR CHRONIC & LIFE THREATENING CONDITIONS:

*Children with life-threatening conditions need an emergency care plan for school.*

Please attach care plan, protocols, and/or emergency care plan.

**Recommendations or Referrals:**

____________________________

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>EMERGENCY PLAN ATTACHED</th>
<th>CARE PLAN OR PRESCRIPTION PLAN ATTACHED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

**Print Name:** ______________________  **Signature:** ____________________________  **Date:** ______

☐ Physician (MD or DO)  ☐ Clinical Nurse Specialist (APN)  ☐ Advanced Practice Nurse (APN)  ☐ Physician Assistant (PA)

**Address:** ____________________________  **Phone:** ____________________________