DELAWARE STUDENT HEALTH FORM – ADOLESCENT Grades 7-12

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.

<u>Ta</u>	lk 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 3 rd dose was prior to the 4 th birthday, a 4 th dose is required.
	MMR ² : 2 doses. The 1 st dose should be given on or after the 1 st birthday. The 2 nd dose should be given after the 4 th birthday.
	☐ Hep B ² : 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.
	☐ Varicella³: 2 doses. The 1 st 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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Clinicians refer to: Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, (3rd Ed.) AAP, 2008

²Disease histories for measles, rubella, mumps and Hepatitis B will not be accepted unless serologically confirmed.

³Varicella disease history must be verified by a health care provider to be exempted from vaccination,

⁴A new school enterer is a child entering a Delaware school district for the <u>first</u> 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.

Name:	Gender:		DOB:
Date:		amine	9
	PARENT		HEALTHCARE PROVIDER COMMENT
Developmental delay (speech, ambulation, other)?	Yes	No	HEALTHCARE PROVIDER COMMENT
Serious injury or illness?			
Medication?			
Hospitalizations?			
When? What for?			
Surgery? (List all) When? What for?			
Ear/Hearing problems?			
Heart problems/Shortness of breath?	Yes	No	
Heart murmur/High blood pressure?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No	
Allergies (food, insect, other)?	Yes	No	
Family history of sudden death before age 50?	Yes	No	
Child wakes during the night coughing?	Yes	No	
Diagnosis of asthma?	Yes	No	
Blood disorders (hemophilia, sickle cell, other)?	Yes	No	
Excessive weight gain or loss?	Yes	No	
Diabetes?	Yes	No	
Loss of function of one or paired organs (eye, ear, kidney, testicle)?			
Seizures?	Yes	No	
Head injuries/Concussion/Passed out?	Yes	No	
Muscle, Bone, or Joint problem/Injury/Scoliosis?	Yes	No	
ADHD/ADD?	Yes	No	
Behavior concerns?	Yes	No	
Eye/Vision concerns? Glasses Contacts Other	Yes	No	
Dental concerns? Braces Bridge Plate Other? Date of exam	Yes	No	
Other diagnoses?	Yes	No	
Does your child have health insurance?	Yes	No	
Does your child have dental insurance	Yes	No	
Information may be shared with appropriate personnel Parent/Guardian Signature	for hea	alth and	educational purposes. Date

CHILD'S NAME	

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 <u>Title 14 Section 804: Immunizations</u>

DTaP/DT	DTaP/DT	DTaP/DT	DTaP/ DT	DTaP/DT
OPV/ IPV	OPV/ IPV	OPV/ IPV	OPV/ IPV	OPV/ IPV
PCV7/ PCV13 / /	PCV7/ PCV13 / /	PCV7/ PCV13 / /	PCV7/ PCV13	PCV7/ PCV13
Hib / /	Hib / /	Hib / /	Hib / /	a managama mada
MMR / /	MMR / /	HepB/HepB-2	HepB/HepB-2	НерВ
VAR	VAR	RV-2/ RV-3	RV-2/ RV-3	RV-3
MCV4	MCV4	HPV / /	HPV / /	HPV / /
Hep A / /	Hep A / /	Td/Tdap	Td/ Tdap	Td / /
Influenza / /	Influenza / /	PPSV23	PPSV23	
Other:	Other:	Other:	Other:	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

Screen	Height:B. (inches) (pounds)	MI: BMI I	Percentile:BP:	Pulse:Other:		
Dental Screen	 □ 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 o Risk Assessment: Mantoux Skin Test: Other: (type)	Date Date	Results: Test l	12 months <u>prior</u> to school entry. Required Test Not Required MMMM		
Other Screen	Vision: Type:	Date:	Results:			

PART IV – COMPREHENSIVE EXAM

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

EXAMINATION NORMAL ABNORMAL General Appearance Skin Eyes Ears Nose/Throat Mouth/Dental Cardiovascular Respiratory Endocrine Gastrointestinal Garito-Uniany Neurological Musculoskeletal Spinal examination Nutritional status Mental health status 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: DIAGNOSIS EMERGENCY PLAN ATTACHED YES NO YES NO YES NO YES NO PLAN ATTACHED PRESCRIPTION PLAN ATTACHED PRESCRIPTION PRESC	PHYSICAL	Check (✓)		HEALTHCARE PROVIDER COMMENT					
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Cardiovascular Respiratory									
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