# 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, and a current (within 2 years) physical examination upon school entry and at ninth (9<sup>th</sup>) grade.

## Talk with your health care provider about important issues<sup>1</sup> regarding your child, such as:

<b>Physical Growth and Development</b> (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

- **Influenza** (seasonal) vaccine is recommended *each year* for *all* children (6 months and up).
- **Human papillomavirus vaccine (HPV)** is recommended for all girls and boys (ages 11 or 12, minimum age 9) to prevent cancers, pre-cancers, and genital warts.
- **Hepatitis A, Meningococcal, and Pneumococcal vaccines** are recommended for certain high risk groups.

### Immunization Requirements for Newly Enrolled Students at Delaware Schools

**GRADES 7-12: DTaP/DTP, Td/Tdap**: 4 or more doses. If the 4<sup>th</sup> dose was prior to the 4<sup>th</sup> birthday, a 5<sup>th</sup> is required. Students, who start the series at age 7 or older, only need a total of 3 doses. A booster dose of Td or Tdap is recommended by the Division of Public Health for all students at age 11 or five years after the last DTap, DTP, or DT dose was administered - whichever is later.

**Polio**: 3 or more doses. If the 3<sup>rd</sup> dose was prior to the 4<sup>th</sup> birthday, a 4<sup>th</sup> dose is required. **MMR**<sup>2</sup>: 2 doses. The 1st dose should be given on or after the 1<sup>st</sup> birthday. The 2<sup>nd</sup> dose

should be given after the 4<sup>th</sup> birthday. **Hep B**<sup>2</sup>: 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC

Hep B<sup>-</sup>: 3 doses. For children 11 to 15 years old, two doses of a vaccine approved by CDC may be used.

No rice 10<sup>3</sup>: 1.2 doses. The 1<sup>st</sup> doses must be given on or often the 1st hinthday. Two doses

**Varicella**<sup>3</sup>: 1-2 doses. The 1<sup>st</sup> dose must be given on or after the 1st birthday. Two doses are required for all new school enterers<sup>4</sup> in: K-9<sup>th</sup> grade in 2012-2013, K-10<sup>th</sup> grade in 2013-2014, K-11<sup>th</sup> grade in 2014-15 and K-12<sup>th</sup> grade in 2015-2016.

Cover March 2012

<sup>&</sup>lt;sup>1</sup>Based on Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, (3<sup>rd</sup> ed.) AAP, 2008

<sup>&</sup>lt;sup>2</sup>Disease histories for measles, rubella, mumps and Hepatitis B will not be accepted unless serologically confirmed.

<sup>&</sup>lt;sup>3</sup>Varicella disease history must be verified by a health care provider to be exempted from vaccination.

<sup>&</sup>lt;sup>4</sup>A 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:	_ Ge	nder:	DOB:
Date:	_ Ex	aminer:	
	PAR	ENT	HEALTHCARE PROVIDER COMMENT
Developmental delay (speech, ambulation, other)?	Yes	No	
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 personne Parent/Guardian	l for hea	alth and	educational purposes.
Signature			Date March 2012

# **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
				1 /
OPV/ IPV	OPV/ IPV	OPV/ IPV	OPV/ IPV	OPV/ IPV
1 1	1 1	1 1	1 1	/ /
PCV7/ PCV13	PCV7/ PCV13	PCV7/ PCV13	PCV7/ PCV13	PCV7/ PCV13
1 1	1 1	1 1	1 1	1 1
Hib	Hib	Hib	Hib	
1 1	1 1	1 1	1 1	
MMR	MMR	HepB /HepB-2	HepB /HepB-2	НерВ
1 1	1 1	1 1	1 1	/ /
VAR	VAR	RV-2/ RV-3	RV-2/ RV-3	RV-3
1 1	1 1	/ /	/ /	/ /
MCV4	MCV4	HPV	HPV	HPV
1 1	1 1	1 1	/ /	/ /
Нер А	Hep A	Td/ Tdap	Td/ Tdap	Td
/ /	/ /	/ /	/ /	/ /
Influenza	Influenza	PPSV23	PPSV23	
1 1	/ /	1 1	1 1	
Other:	Other:	Other:	Other:	Other:
/ /	/ /	/ /	/ /	/ /

#### **PART III – SCREENING & TESTING**

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

Screen	Height:Weight:	BMI: BMI	Percentile:BP:	Pulse:Other:			
Dental Screen	<ul> <li>□ Problem Identified: Referred for treatment</li> <li>□ No Problem: Referred for prevention</li> <li>□ No Referral: Already receiving dental care</li> </ul>						
Tuberculosis Screen	All new enterers must have TB test Risk Assessment: Mantoux Skin Test: Other: (type)	Date	Results: At-Ris	k No Risk MM			
Other Screen	Vision: Type:	Date:	_ Results:				

## PART IV – COMPREHENSIVE EXAM

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

PHYSICAL	Ch	neck (✔)	HEALTH	CARE PROV	IDER COMN	MENT
<b>EXAMINATION</b>	NORMAL	ABNORMAL				
General Appearance						
Skin						
Eyes	<u> </u>					
Ears	<u> </u>					
Nose/Throat	<u> </u>					
Mouth/Dental	<u> </u>					
Cardiovascular	<u> </u>					
Respiratory						
Endocrine						
Gastrointestinal						
Genito-Urinary						
Neurological						
Musculoskeletal						
Spinal examination						
Nutritional status						
Mental health status						
	. 1 .1		1 1 3 T 1 A 1 . TS	(03.1.1.70)		
Recommendations or		ent with information on Spo	ecial Needs Alert P	rogram (SNAP)	for EMS.	
				NCY PLAN	CARE PI PRESCR PLAN AT	<b>IPTION</b>
	Referrals:		EMERGEN	NCY PLAN	CARE PI PRESCR	<b>IPTION</b>
	Referrals:		EMERGEN ATTA	NCY PLAN CHED	CARE PI PRESCR PLAN AT	AIPTION TACHED
	Referrals:		EMERGEN ATTA	NCY PLAN CHED	CARE PI PRESCR PLAN AT	AIPTION TACHED
	Referrals:		EMERGEN ATTA	NCY PLAN CHED	CARE PI PRESCR PLAN AT	AIPTION TACHED
	Referrals:		EMERGEN ATTA	NCY PLAN CHED	CARE PI PRESCR PLAN AT	AIPTION TACHED
	Referrals:		EMERGEN ATTA	NCY PLAN CHED	CARE PI PRESCR PLAN AT	AIPTION TACHED
	Referrals:		EMERGEN ATTA	NCY PLAN CHED	CARE PI PRESCR PLAN AT	AIPTION TACHED
	Referrals:		EMERGEN ATTA	NCY PLAN CHED	CARE PI PRESCR PLAN AT	AIPTION TACHED
Recommendations or 2	DIAGNOSIS	3	EMERGEN ATTA YES	NCY PLAN CHED NO	CARE PI PRESCR PLAN AT YES	AIPTION TACHED NO