DELAWARE STUDENT HEALTH FORM – CHILDREN
PreK- Grade 6

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. A physical prior to 9th Grade is strongly recommended for school year 2012-2013 and will be a requirement for school year 2013-2014.

Talk with your health care provider about these other important issues[1] regarding your child, such as:

- ☐ **School** (readiness or adaptation, after school, parent-teacher communication, maturity, performance, special services)
- ☐ **Mental and Physical Activity** (healthy weight, well-balanced diet, physical activity, limited screen time)
- ☐ **Emotional Well-Being** (family time, social interactions, self-esteem, resolving conflicts, friends)
- ☐ **Physical Growth & Development** (dental care, healthy eating, puberty)
- ☐ **Injury & Illness Prevention & Safety** (seat belt or booster seat, bicycle safety, swimming, sexual abuse, guns, fire safety, supervision, sunscreen, internet, infection, disaster planning)
- ☐ **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

KINDERGARTEN[2]:
DTaP: At least 4 doses. The last dose must be given on or after 4th birthday
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR[3]: 2 doses. The 1st dose must be given on or after the 1st birthday. The 2nd dose must be given after the 4th birthday.
Hep B[3]: 3 doses
Varicella[4]: 2 doses. The 1st dose must be given on or after the 1st birthday and the 2nd dose at kindergarten entry.

GRADES 1-6:
DTaP/Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday
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: At least 3 doses. The last dose must be given on or after 4th birthday
MMR[3]: 2 doses. The 1st dose must be given on or after the 1st birthday. The 2nd dose must be given after the 4th birthday.
Hep B[3]: 3 doses. For children 11 to 15 years old two doses of a vaccine approved by CDC may be used.
Varicella[4]: 2 doses. The 1st dose must be given on or after the 1st birthday and the 2nd dose at kindergarten/school entry.

[1] Based on Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, (3rd ed.) AAP, 2008
[2] Children who enter school prior to age four shall follow current Delaware Division of Public Health recommendations.
[3] Disease histories for measles, rubella, mumps and Hepatitis B will not be accepted unless serologically confirmed.
[4] Varicella disease history must be verified by a health care provider to be exempted from vaccination.

CHILD'S NAME_____

PART I – HEALTH HISTORY

To be completed by parent/guardian prior to exam.
The healthcare provider should review and provide comments in the shaded column.

Name:_____ **Gender:**_____ **DOB:**_____

Date:_____ **Examiner:**_____

To be completed and signed by parent/guardian and evaluated by health care provider

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

Parent/Guardian Signature **Date**

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. Regulations is located at Title 14 Section 804 Immunizations***

DTP/Hib 1 / /	**DTP/Hib 2** / /	**DTP/Hib 3** / /	**DTP/ Hib 4** / /	**DTaP/Hib 4** / /
DTP/DTaP 1 / /	**DTP/DTaP 2** / /	**DTP/DTaP 3** / /	**DTP/DTaP 4** / /	**DTP/DTaP 5** / /
DT/Td 1 / /	**DT/Td 2** / /	**DT/Td 3** / /	**DT/Td 4** / /	**DT/Td 5** / /
Tdap / /	**MMR 1** / /	**MMR 2** / /		
OPV/IPV 1 / /	**OPV/IPV 2** / /	**OPV/IPV 3** / /	**OPV/IPV 4** / /	**OPV/IPV 5** / /
Hib 1 / /	**Hib 2** / /	**Hib 3** / /	**Hib 4** / /	
Hep B 1 (2 dose Version Only) / /	**Hep B 2 (2 dose Version Only)** / /	**Hep B/Hib 1** / /	**Hep B/Hib 2** / /	**Hep B/Hib 3** / /
Varicella 1 / /	**Varicella 2** / /	**HepB 1** / /	**HepB 2** / /	**HepB 3** / /

CHILD'S NAME_____

Pneumococcal Conjugate 1 / /	**Pneumococcal Conjugate 2** / /	**Pneumococcal Conjugate 3** / /	**Pneumococcal Conjugate 4** / /	
Pneumococcal Polysaccharide1 / /	**Pneumococcal Polysaccharide 2** / /	**Hep A 1** / /	**Hep A 2** / /	
Influenza 1 / /	**Influenza 2** / /	**Other:** / /	Other: / /	

PART III – SCREENING & TESTING

Screen	**Height: _____Weight: _____BMI: _____ BMI Percentile: _____BP: _____Pulse: _____Other: _____** (inches) (pounds)
Dental Screen	☐ Problem Identified: Referred for treatment ☐ No Problem: Referred for prevention ☐ No Referral: Already receiving dental care
Tuberculosis Screen	TB test or TB Risk Assessment required for all new enterers within 12 months of entry (Reg. 805) **Risk Assessment:** **Date**_____ **Results**: ☐ At-Risk ☐ No Risk **Mantoux Skin Test:** **Date**_____ **Results**:_____MM **Other:** (type)_____ **Date**_____ **Results**:_____MM
Lead Test	Blood lead test required for children age 6 months through 6 years **Date**:_____ **Results**:_____
Other	**Type**:_____ **Date**:_____ **Results**:_____

PART IV – COMPREHENSIVE EXAM

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

PHYSICAL EXAMINATION	Check (✓) NORMAL	ABNORMAL	REFERRAL	HEALTHCARE PROVIDER COMMENT
General Appearance				
Skin				
Eyes				
Ears				
Nose/Throat				
Mouth/Dental				
Cardiovascular				
Respiratory				
Thyroid				
Gastrointestinal				
Genito-Urinary				
Neurological				
Musculoskeletal				
Spinal examination				
Nutritional status				
Mental health status				

CHILD'S NAME_____

FOR CHRONIC & LIFE THREATENING CONDITIONS:

Children with life-threatening conditions need an emergency care plan in place.

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

Please provide the parent with information on Special Needs Alert Program (SNAP) for EMS.

Recommendations or Referrals:_____

_____

_____

YES	NO	DIAGNOSIS	EMERGENCY PLAN ATTACHED		CARE PLAN OR PRESCRIPTION PLAN ATTACHED	
			YES	NO	YES	NO

Print Name: _____ **Signature:** _____**Date:** _____

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

☐**Physician Assistant (PA)**

Address: _____**Phone:** _____