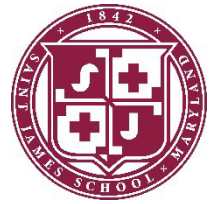


SAINT JAMES STUDENT HEALTH FORM – ADOLESCENT



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 Maryland schools must provide documentation of current immunizations.

Immunizations Required for Enrolled Students at Saint James School

FORMS II-VI

DTaP/DTP,Tdap: Completion of the primary series plus an adolescent booster dose of Tdap administered at age 11-12 or prior to entry into Form II.

Polio: 3 or more doses. If 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.

Hepatitis B: 3 doses

Varicella: 2 doses. The 1st dose must be given on or after the 1st birthday.

Meningitis ACWY: 1 dose is required on or after the 11th birthday. A 2nd dose on or after 16th birthday.

Meningitis B: 2 doses given on or after 16th birthday per vaccine protocol

Covid: TBD (requirement will be reviewed per CDC updates and recommendations)

Influenza: annually, September-November

Immunizations strongly recommended by Maryland Public Health Department

Hepatitis A: 2 doses 6-18 months apart

Human papillomavirus (HPV9): 2 doses if given under age 15, 3 doses if over age 15.

Pneumococcal (PPSV or PCV13): certain high-risk groups

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: _____ **Healthcare Provider Signature:** _____

	PARENT		HEALTHCARE PROVIDER COMMENT
Developmental delay (speech, ambulation, other)?	Yes	No	
Serious injury or illness?	Yes	No	
Medication?	Yes	No	
Hospitalizations? When? What for?	Yes	No	
Surgery? (List all) When? What for?	Yes	No	
Ear/Hearing problems?	Yes	No	
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)?	Yes	No	
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 for health and educational purposes.

Parent/Guardian

Signature

Date

PART II IMMUNIZATIONS

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

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Covid: TBD (requirement will be reviewed per CDC updates and recommendations)

Influenza: annually, September-November

PLEASE ATTACH OFFICIAL VACCINE DOCUMENTATION FROM MEDICAL OFFICE

Child is fully immunized per Saint James Requirements

☐ Yes ☐ No

PART III – SCREENING & TESTING

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

HEIGHT _____ WEIGHT _____ BP _____ PULSE _____ MALE _____ FEMALE _____

VISION R 20/ _____ L 20/ _____ CORRECTED? YES _____ NO _____

HEARING NORMAL _____ ABNORMAL _____ COMMENTS? _____

TO BE COMPLETED BY HEALTHCARE PROVIDER AND PATIENT. (Please answer all questions)

Has a family member or close contact had tuberculosis?

Has a family member had a positive tuberculosis skin test?

Are you from a high-risk country?

Have you traveled to a high-risk country for more than 4 weeks in the last year?

A PPD SKIN TEST OR QUANTIFERON/T-SPOT TESTING IS REQUIRED ANNUALLY FOR STUDENTS WHO ANSWER YES TO ANY OF THE ABOVE QUESTIONS.

Date of test (if indicated) _____ Results _____

PART IV – COMPREHENSIVE EXAM

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

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

DIAGNOSIS	EMERGENCY PLAN ATTACHED		MEDICATION AUTHORIZATION FORM ATTACHED	
	YES	NO	YES	NO

_____Cleared for sports without restrictions.

_____NOT cleared:

_____pending further evaluation

_____for any sports

_____for certain sports

Reason _____

Print Name: _____ Signature: _____ Date: _____

Address: _____ Phone: _____

OFFICE STAMP: