

# 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:

- 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**
  - **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 1<sup>st</sup> 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 may be used.

**Varicella<sup>3</sup>:** 1-2 doses. The 1<sup>st</sup> dose must be given on or after the 1<sup>st</sup> 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.

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

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

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

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

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 last column.*

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_  
Date: \_\_\_\_\_ Examiner: \_\_\_\_\_

	PARENT		HEALTHCARE PROVIDER COMMENT
	Yes	No	
Developmental delay (speech, ambulation, other)?			
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? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Other _____	Yes	No	
Dental concerns? <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> 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  
 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 / /	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 / /	
MMR / /	MMR / /	HepB/HepB-2 / /	HepB/HepB-2 / /	HepB / /
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: / /

**PART III – SCREENING & TESTING**

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

<b>Screen</b>	Height: _____ Weight: _____ BMI: _____ BMI Percentile: _____ BP: _____ Pulse: _____ Other: _____ (inches) (pounds)
<b>Dental Screen</b>	<input type="checkbox"/> <b>Problem Identified:</b> Referred for treatment <input type="checkbox"/> <b>No Problem:</b> Referred for prevention <input type="checkbox"/> <b>No Referral:</b> Already receiving dental care
<b>Tuberculosis Screen</b>	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: <input type="checkbox"/> At-Risk <input type="checkbox"/> No Risk Mantoux Skin Test: Date _____ Results: _____ MM Other: (type) _____ Date _____ Results: _____ MM
<b>Other Screen</b>	Hearing: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Date Vision: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Date Other: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Date

CHILD'S NAME \_\_\_\_\_

**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			
Head/Neck			
Eyes			
Ears			
Nose/Throat			
Mouth/Dental			
Cardiovascular			
Respiratory			
Endocrine			
Gastrointestinal			
Genito-Urinary			
Neurological			
Musculoskeletal			
Skin 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.

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

Recommendations or Referrals: \_\_\_\_\_

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: \_\_\_\_\_