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. Additionally, a current (within 2 years) health examination is required upon school entry.

Talk with your health care provider about 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, abuse protection, guns, fire safety, supervision, sunscreen, internet, infection, disaster planning)
- ☐ **Immunizations**

Immunizations *Required* for Newly Enrolled Students at Delaware Schools

KINDERGARTEN[2]:

- ☐ **DTaP/DTP:** 4 or more doses. If the 4th dose was prior to the 4th birthday, a 5th dose is required.
- ☐ **Polio:** 3 or more doses. If the 3rd dose was prior to the 4th birthday, a 4th dose is required.
- ☐ **MMR[3]:** 2 doses. The 1st dose should be given on or after the 1st birthday. The 2nd dose should be given after the 4th birthday.
- ☐ **Hep B[3]:** 3 doses.
- ☐ **Varicella[4]:** 2 doses. The 1st dose should be given on or after the 1st birthday and the 2nd dose after the 4th birthday.

GRADES 1-6:

- ☐ **DTaP/DTP:** 4 or more doses. If the 4th dose was prior to the 4th birthday, a 5th dose 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 3rd dose was prior to the 4th birthday, a 4th dose is required.
- ☐ **MMR[3]:** 2 doses. The 1st dose should be given on or after the 1st birthday. The 2nd dose should 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 after the 4th birthday.

Immunizations *Strongly* Recommended by the Delaware Division of Public Health

- ☐ **Influenza (seasonal) vaccine:** *each year* for *all* children (6 months and up).
- ☐ **Tetanus-Diphtheria-Pertussis (Tdap):** booster at age 11 or five years after the last dose
- ☐ **Meningococcal (MCV4):** all children at 11 or 12 years, and a booster does at age 16
- ☐ **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

[1] Clinicians refer to: 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 last column.

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

Date:_____ **Examiner:**_____

	PARENT		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 personnel for health and educational purposes.

Parent/Guardian Signature **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. Regulations 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: / /

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: _____ (inches) **Weight:** _____ (pounds) **BMI:** _____ **BMI 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 or TB Risk Assessment, which must be done within 12 months prior to school entry.

Risk Assessment: **Date**_____ **Results:** ☐ Test Required ☐ Test Not Required

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 Screen

Hearing: **Type:**_____ **Date:**_____ **Results:**_____ **Referral:** ☐ No ☐ Yes _____ Date

Vision: **Type:**_____ **Date:**_____ **Results:**_____ **Referral:** ☐ No ☐ Yes _____ Date

Other: **Type:**_____ **Date:**_____ **Results:**_____ **Referral:** ☐ No ☐ Yes _____ Date

CHILD'S NAME_____

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				

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		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:** _____