Student Name (please print) _____ Date of Birth _____
Last First Form

St. Paul's School

Clark House
2017-18 PHYSICAL EXAMINATION/IMMUNIZATION RECORD
REQUIRED FOR ALL STUDENTS
TO BE COMPLETED BY A HEALTH CARE PROVIDER

TO PROVIDER: *Please review the student's medical history and complete the following form. Comment on all positive findings and on any significant medical condition(s).* **This exam must be completed after September 1, 2016.** *This form, or a doctor's comparable form, must be completed in its entirety and submitted on or before* **June 15, 2017.**

Student's name _____ Gender_____

Date of exam_____ Blood pressure _____ Pulse_____ Height_____ (INCHES ONLY) Weight _____ (POUNDS ONLY)

List current medication(s); or attach separate sheet:

Med./dose schedule _____ Diagnosis _____

Med./dose schedule _____ Diagnosis _____

Med./dose schedule _____ Diagnosis _____

Allergies to: ❑ No known ❑ Food ❑ Medication ❑ Environment Does the student have an Epi Pen? ❑ Yes ❑ No

List specific allergens _____

Does the student wear corrective lenses? ❑ Yes ❑ No If yes: ❑ Contact Lenses ❑ Glasses ❑ Both

Previous medical history (list hospitalization(s), surgerie(s), significant illness(es)_____

_____

_____

ABNORMALITIES	Y	N
HEENT		
Thyroid		
Lung		
Cardiovascular		
Abdomen		
Hernia		
Genitals		
Extremities/Joint		
Skin		
Neurological		
Mental status		

If yes, please explain _____

_____

_____

_____

Any special accommodations?_____

_____

_____

_____

Health Care Provider's exam and special recommendations:

Medical and/or mental health diagnosis, explain_____

_____

❑ No athletic participation, explain ❑ Limited athletic participation, explain ❑ Clearance withheld until_____ ❑ Unlimited athletic participation

Comments _____

_____

HAVE YOU COMPLETED BOTH SIDES OF THIS FORM?

Student Name (please print) _____ Date of Birth _____

New Hampshire law requires documentary proof of acceptable immunizations of all students prior to entrance to any school in the state. The record below must be signed by a health care provider. **It must indicate month, day, and year of vaccine administration.** *Students may also present laboratory evidence of immunity.* (If religious exemption applies, please attach Certificate of Religious Exemption.)

REQUIRED IMMUNIZATIONS (Enter dates: month, day, year)	**DATE** (M / D / Y)	**DATE** (M / D / Y)	**DATE** (M / D / Y)	**DATE** (M / D / Y)	**DATE** (M / D / Y)
POLIO: 3 doses if they are all IPV or all OPV, provided 3rd dose was given after 4th birthday; or 4 doses of any combination of OPV and IPV	_____ ❑ OPV ❑ IPV	_____ ❑ OPV ❑ IPV	_____ ❑ OPV ❑ IPV	_____ ❑ OPV ❑ IPV	_____ ❑ OPV ❑ IPV
DPT/DT/DtaP: 4 doses, provided 4th dose was given on or after 4th birthday					
HEPATITIS B: 3 doses required					
MMR (Measles, Mumps, and Rubella): 2 doses required; 1st dose must be after 12 months of age, 2nd dose at least 28 days after 1st dose					
TDAP BOOSTER A Tdap booster is required, prior to admission, regardless of last Td					
VARICELLA (chickenpox): 2 doses required; **if student has not had the disease** **VARICELLA (history of disease):** ❑ Yes ❑ No approx. date_____					

OR AS SEPARATE IMMUNIZATIONS (Enter dates: month, day, year)	**DATE**	**DATE**	**DATE**
MEASLES (Rubeola): 2 doses of vaccine; 1st dose must be after 12 months of age, 2nd dose at least 28 days after 1st dose			
MUMPS: 1 dose must be after 12 months of age			
RUBELLA (German Measles): 1 dose must be after 12 months of age			

OTHER IMMUNIZATIONS (not required) (Enter dates: month, day, year)	**DATE**	**DATE**	**DATE**
HAEMOPHILUS INFLUENZAE TYPE B:			
HEPATITIS A: 2 doses			
❑ **HPV (Human Papilloma Virus):** 3 doses ❑ HPV 9: 3 doses			
MENINGITIS: (specify type) ❑ Menomune ❑ Menactra (recommended)			
MENINGITIS B: (specify type) ❑ Bexsero ❑ Trumenba			
OTHER:			

As the Health Care Provider, I have examined this child, his or her immunization record, and TB test.

Signature of Health Care Provider_____ Date_____

Provider name (please print) _____ Telephone _____

Provider address _____

_____

_____