



## CLARK HOUSE 2021-22 PHYSICAL EXAMINATION/IMMUNIZATION RECORD

**REQUIRED FOR ALL STUDENTS. TO BE COMPLETED BY HEALTH CARE PROVIDER (NON-FAMILY MEMBER)**

**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, 2020. This form, or a doctor's comparable form, must be completed in its entirety and submitted on or before June 15, 2021.**

Student's name \_\_\_\_\_ Gender \_\_\_\_\_

Date of exam \_\_\_\_\_ Blood pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
(INCHES ONLY) (POUNDS ONLY)

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

Med./dose schedule \_\_\_\_\_ Diagnosis \_\_\_\_\_

Med./dose schedule \_\_\_\_\_ Diagnosis \_\_\_\_\_

Med./dose schedule \_\_\_\_\_ Diagnosis \_\_\_\_\_

Allergies:  No known  Food  Medication  Environment Does student have Epi Pen?  Yes  No If yes: attach allergy treatment plan

List specific allergens \_\_\_\_\_

Does student have history of asthma?  Yes  No If yes: attach asthma treatment plan

Has student tested positive for COVID-19?  Yes  No Date \_\_\_\_\_ Type of test \_\_\_\_\_

Previous medical history (list hospitalization(s), surgery(ies), significant illness(es)) \_\_\_\_\_

	NORMAL	ABNORMAL	COMMENTS OR RECOMMENDATIONS
Skin			
HEENT			
Neck, Thyroid			
Cardiovascular (murmurs, pulses)			
Chest and Lungs			
Abdomen			
Musculoskeletal (ROM, Strength)			
Neurological			
Genitals			
Menstrual Status			

### Health Care Provider's exam and special recommendations or accommodations:

Medical and/or mental health diagnosis, explain \_\_\_\_\_  
 \_\_\_\_\_

ANSWER REQUIRED:  Unlimited athletic participation  Limited athletic participation, explain  No athletic participation, explain

Limited or no participation explanation \_\_\_\_\_  
 \_\_\_\_\_

**HAVE YOU COMPLETED BOTH SIDES OF THIS FORM?**

2021-22 PHYSICAL EXAMINATION/IMMUNIZATION RECORD

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 (01/20/18). 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 3 <sup>rd</sup> dose was given after 4 <sup>th</sup> birthday; or 4 doses of any combination of OPV and IPV	<input type="checkbox"/> OPV <input type="checkbox"/> IPV	<input type="checkbox"/> OPV <input type="checkbox"/> IPV	<input type="checkbox"/> OPV <input type="checkbox"/> IPV	<input type="checkbox"/> OPV <input type="checkbox"/> IPV	<input type="checkbox"/> OPV <input type="checkbox"/> IPV
DPT/DT/DtaP: 4 doses, provided 4 <sup>th</sup> dose was given on or after 4 <sup>th</sup> birthday					
HEPATITIS B: 3 doses required					
MENINGITIS: (specify type) <input type="checkbox"/> Menomune <input type="checkbox"/> Menactra (recommended)					
MMR (Measles, Mumps, and Rubella): 2 doses required; 1 <sup>st</sup> dose must be after 12 months of age, 2 <sup>nd</sup> dose at least 28 days after 1 <sup>st</sup> dose					
TDAP BOOSTER A Tdap booster is required, prior to admission, regardless of last Td or Dtap					
VARICELLA (chickenpox): 2 doses required; if student has not had the disease VARICELLA (history of disease): <input type="checkbox"/> Yes <input type="checkbox"/> No approx. date _____					
OR AS SEPARATE IMMUNIZATIONS (Enter dates: month, day, year)	DATE	DATE	DATE		
MEASLES (Rubeola): 2 doses of vaccine; 1 <sup>st</sup> dose must be after 12 months of age, 2 <sup>nd</sup> dose at least 28 days after 1 <sup>st</sup> 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					
<input type="checkbox"/> HPV (Human Papilloma Virus): 2 or 3 doses <input type="checkbox"/> HPV 9: 2 or 3 doses					
INFLUENZA (most recent):					
MENINGITIS B: (specify type) <input type="checkbox"/> Bexsero <input type="checkbox"/> Trumenba					
COVID-SARS VACCINE: Type:					
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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Student Name (please print) \_\_\_\_\_ Date of Birth \_\_\_\_\_

**TO PROVIDER: Please complete the following form. This evaluation must be completed before June 15, 2021.**

**Tuberculosis Medical Evaluation**

ATTENTION: If the student has been home or travelling to one of the areas listed below for more than 30 consecutive days over the summer, you must mark YES to the question below. A PPD is required before arriving to the School in the fall.

Angola	Cambodia	DR Congo	Kazakhstan	Moldova	Pakistan	Somalia	Uganda
Azerbaijan	Cameroon	Ethiopia	Kenya	Mozambique	Papua New Guinea	South Africa	Ukraine
Bangladesh	Central African Republic	Ghana	Kyrgyzstan	Myanmar	Peru	Swaziland	Uzbekistan
Belarus	Chad	Guinea-Bissau	Lesotho	Namibia	Philippines	Tajikistan	Vietnam
Botswana	China	India	Liberia	Nigeria	Russian Federation	Tanzania	Zambia
Brazil	Congo	Indonesia	Malawi	North Korea	Sierra Leone	Thailand	Zimbabwe

Does the student reside in one of the countries listed above?  
 OR Has the student ever travelled for more than 30 consecutive days to one of the countries listed above?  
 OR Has the student ever had close contact with anyone who was sick with TB?  
 Yes (If yes, continue with remaining sections)       No (If no, sign below and form is complete)

Has the student had BCG?    Yes       No

**SECTION A**

Student is required to have a Mantoux/PPD skin test within 3 months of arriving at St. Paul's School.

Date PPD planted (m/d/year) \_\_\_\_\_ Date PPD read, within 48-72 hours (m/d/year) \_\_\_\_\_  
 Results (mm) \_\_\_\_\_ Interpretation    Positive    Negative

If the PPD reading is negative, no further action is needed; if positive, continue to Section B.

**SECTION B**

Student must have a serum interferon gamma release assay (IGRA) drawn within 3 months of arriving at St. Paul's School. This may be a Tspot or Quantiferon test.

Date blood drawn (m/d/year) \_\_\_\_\_    Quantiferon    Tspot / RESULTS    Positive    Negative    Intermediate

If result is negative, no further action is needed; if result is positive or intermediate, continue to Section C.

**SECTION C**

Student must have a chest x-ray within 3 months of arriving at St. Paul's School. A chest x-ray without a serum test will not be accepted.

Date of chest x-ray (m/d/year) \_\_\_\_\_ Please attach a copy of the x-ray report.

RESULTS    Read as negative/normal. Treatment for latent TB must be considered.

Read as positive/abnormal. Treatment for active TB must be documented below:

Drug(s) \_\_\_\_\_ Dose(s) \_\_\_\_\_

Dates of treatment \_\_\_\_\_ Duration of treatment \_\_\_\_\_

Signature of Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_

Provider name (please print) \_\_\_\_\_ Phone \_\_\_\_\_

Provider address \_\_\_\_\_