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

St. Paul's School

Clark House

2023-24 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, 2022.** *This form, or a doctor's comparable form, must be completed in its entirety and submitted on or before* **May 1, 2023.**

Student's name_____ Gender_____

Date of exam _____ Blood pressure_____ Pulse _____ Height _____ Weight_____
(attach growth chart if available) (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? ❑ No ❑ Yes: ATTACH TREATMENT PLAN

List specific allergens_____

Does student have history of asthma? ❑ No ❑ Yes: ATTACH TREATMENT PLAN

Has student tested positive for COVID-19? ❑ No ❑ Yes Date_____ Type of test_____Previ-

ous 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 _____

_____

Has student ever been prohibited from sports/athletics? ❑ No ❑ Yes, explain_____

_____

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

Limited or no particpation explanation _____

_____

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 (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 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					
MENINGITIS: (specify type) ❑ Menomune ❑ Menactra (recommended)					
COVID-SARS VACCINE: 2 doses and 1 booster dose 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 or Dtap**					
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): 2 or** 3 doses ❑ HPV 9**: 2 or** 3 doses			
INFLUENZA (most recent):			
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.

REQUIRED: Health Care Provider signature _____ 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 May 1, 2023.**

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 _____

_____