Holy Cross School
Dover, Delaware

Child's Name:		Grade Entering 2018-2019:	

PART I – 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: / /

PART II– 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

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: ☐ At-Risk ☐ No Risk
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 _____

(over)

PART III - COMPREHENSIVE EXAM

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

PHYSICAL EXAMINATION	Check (✓)			HEALTHCARE PROVIDER COMMENT
	NORMAL	ABNORMAL	REFERRAL	
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.
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: _____