

**Saint Michael School
North Andover, MA 01845**

School Health Requirements

Welcome to Saint Michael's School!

In order to ensure the safety of your child, the Massachusetts Department of Public Health and Federal School Immunization Law requires proof of immunization and physical exam, within one year, before entering school. If your child has yet to receive these immunizations or have a recent physical exam, please contact your child's physician and make arrangements to ensure completion or requirements before your child starts school. Massachusetts State Law suggests that children should not be present in school without physician documented proof of immunizations and recent physical exam. The following chart provides the immunizations and other additional information necessary before entry.

Requirements/recommendations*	By 2 years old	By Kindergarten	By Grade 7
Mumps, Measles, Rubella (MMR)	1 dose	2 doses	2 doses
Diphtheria, Tetanus, Pertussis (DTaP, Tdap)	4 or more doses	5 doses	5 doses and 1 booster
Inactivated Poliovirus (IPV)	3 or more doses	4 doses	3 or more doses
Hepatitis B	3 doses	3 doses	3 doses
Varicella Or <u>physician</u> documented proof	1 dose	NEW- 2 doses!	NEW- 2 doses!
Haemophilus influenza type b (Hib)	4 doses	None unless previously received	None unless previously received
Pneumococcal (PCV)*	4 doses recommended		Booster if recommended earlier
Meningococcal*			1 dose recommended
Influenza*	Recommended if at risk	Recommended if at risk	Recommended if at risk
TB risk/ Mantoux results	Risk should be noted	Risk should be noted	Risk should be noted
Physical Exam	Within one year	Within one year	Within one year
Lead Screening	Recommended at any age	Must be noted prior to entrance	Should be noted from earlier testing

Please return the following as soon as possible:

- **Pre-entry School Health Questionnaire** (if included)
- **Emergency Card Information** (if included)
- **Updated physical exam within one year of entry date** (Most physicians use their own routine physical exam/camp forms, and that is acceptable. If you need a form, you can download one from the SMS website.)
- **All required physician documented immunization dates/information as noted above**
- **Previous school health record if available**

Please note: Students with specific health care requirements or concerns- please stop by or call the health office before your child enters SMS to assure the health and safety of your child. Required forms for you and your physician to complete before entering SMS may be downloaded from our website or picked up from the Health Office. If necessary, a formal meeting may be arranged.

Your cooperation in these important matters is greatly appreciated. Please do not hesitate to call with any questions or concerns. I look forward to working with you and your child. (Phone # 978-686-1862, ext.13 , Fax # 978 688-5144.)

Best regards and stay healthy,
Linda Sullivan, RN, BSN, NCSN

Saint Michael School
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School Entry Health Information Questionnaire

Dear Parent/guardian,

Thank you for taking the time to answer these important questions to assure a healthy start for your child at Saint Michael School. Parents of children with special health care needs should contact the school nurse or Principal to develop an Individual Health Care Plan, if necessary.

Best to you, Linda Sullivan, RN, BSN, NCSN

Child's Name: _____ DOB: _____ Male or Female (please circle) Grade Entering: _____

- Has your son/daughter ever been hospitalized? YES ___ NO ___ If yes, list date/s and reason:
- Vision and Hearing Status: (Please check appropriate response. If you answer "yes" to any of the questions, please explain further in the space provided below.)

Does your child have any vision problem/s?	YES ___ NO ___
Have his/her eyes ever looked "crossed"?	YES ___ NO ___
Does your child wear glasses?	YES ___ NO ___
Has your child had history of frequent ear infections?	YES ___ NO ___
Does your child have difficulty hearing?	YES ___ NO ___
Does your child have hearing aides?	YES ___ NO ___

Explain further if necessary:
- Does your son/daughter have any allergies? YES ___ NO ___
If yes, please check all that may apply and describe the type of reaction/symptom/s, and how it is treated.
Food/s: _____ Environmental (Pollen/ragweed/mold/dust, etc): _____
Insect/s: _____ Latex: _____ Other: _____
Is emergency epinephrine (Epi-pen/Twinjet/or generic medication) prescribed for your child? YES ___ NO ___
- Does your son/daughter take any medication on a daily basis? YES ___ NO ___
If yes, please list medication/s and diagnosis/reason for administration:
- Please indicate if your son/daughter has or has had any of the following: ASTHMA _____, DIABETES_Type I or II, HEADACHES _____, HEART CONDITION _____, SEIZURES/CONVULSIONS _____, FREQUENT NOSEBLEEDS _____, BOWEL or BLADDER CONCERNS _____, CHRONIC ILLNESS _____, FREQUENT SORE THROAT/STREP _____, OTHER _____.
If you checked any of the preceding, please explain:
- Is there any health issue/s (behavioral, emotional, or physical) pertaining to your child that we should be aware of in order to better care for your child at school?
- Is your son/daughter potty-trained? YES ___ NO ___ If no, you must speak with Mrs. Rogge and/or Mrs. Gosselin before registering for school.
- Do you have medical insurance for your child? YES NO
If no, please speak with your school nurse or contact the Health Care for All Hotline at 800-272-4232 and/or visit the website at www.mass.gov/dma for low-cost or free health insurance for your child.

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name _____ Male Female Date of Birth: _____

Medical History

Pertinent Family History

Current Health Issues

Y N
 Allergies: Please list: Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi-Pen®: Yes No
 Asthma: Asthma Action Plan Yes No (Please attach)
 Diabetes: Type I Type II
 Seizure disorder: _____
 Other (Please specify) _____

Current Medications (if relevant to the student's health and safety) Please circle those administered in school; a separate medication order form is needed for each medication administered in school.

Physical Examination

Date of Examination: _____

Hgt: _____ (_____ %) Wgt: _____ (_____ %) BMI: _____ (_____ %) BP: _____

(Check = Normal / If abnormal, please describe.)

<input type="checkbox"/> General _____	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Extremities _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Neurologic _____
<input type="checkbox"/> HEENT _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental/Oral _____	<input type="checkbox"/> Genitalia _____	

Screening:

	(Pass) (Fail)		(Pass) (Fail)		(Pass) (Fail)
Vision: Right Eye	<input type="checkbox"/> <input type="checkbox"/>	Hearing: Right Ear	<input type="checkbox"/> <input type="checkbox"/>	Postural Screening:	<input type="checkbox"/> <input type="checkbox"/>
Left Eye	<input type="checkbox"/> <input type="checkbox"/>	Left Ear	<input type="checkbox"/> <input type="checkbox"/>	(Scoliosis/Kyphosis/Lordosis)	
Stereopsis	<input type="checkbox"/> <input type="checkbox"/>				

Laboratory Results: Lead _____ Date _____ Other _____

The entire examination was normal:

Targeted TB Skin Testing: Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):

Date of PPD: _____; Results: _____ mm.

Referred for evaluation to: _____ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Fine/Gross Motor Deficit
<input type="checkbox"/> Emotional/Social	<input type="checkbox"/> Behavior	<input type="checkbox"/> Other	

Comments/Recommendations:

Y N This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:

Y N Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.

Signature of Examiner Circle: MD, DO, NP, PA Date _____

Please print name of Examiner.

Group Practice _____ Telephone _____

Address _____ City _____ State _____ Zip Code _____

Please attach additional information as needed for the health and safety of the student.

MDPH 05/23/11

CERTIFICATE OF IMMUNIZATION

Name: _____ Date of Birth: / / Sex: M F

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1		Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1	
	2			2	
	3			3	
	4		Measles, Mumps, Rubella (MMR, MMRV)	1	
1		2			
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, Td, Tdap)	2		Varicella (Var, MMRV)	1	
	3			2	
	4		Meningococcal Conjugate (MCV4) or Polysaccharide (MPSV4)	1	
	5			2	
	6		Seasonal Influenza Inactivated (Intramuscular) or Live (Intranasal)	1	
	7			2	
1		3			
Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib)	2		4		
	3		H1N1 Influenza Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
	1		Pneumococcal Polysaccharide (PPV23)	1	
2		2			
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib)	3		Hepatitis A (HepA, HepA-HepB)	1	
	4			2	
	5		Human Papillomavirus (HPV)	1	
	1			2	
	2			3	
Pneumococcal Conjugate (PCV7)	3		Other:		
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

* Must also check Chickenpox History box.

Chickenpox History
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox.
Reliable history may be based on: <ul style="list-style-type: none"> • physician interpretation of parent/guardian description of chickenpox • physical diagnosis of chickenpox, or • serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (please print): _____ **Date:** / /

Signature: _____

Facility name: _____