Stratham Memorial School

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HEALTH RECORD for _____School Year _____

Date of birth _____ Sex _____ Parents/Guardians_____

Stratham School Board/SAU 16-Physical Examination of Students

JLCA There shall be a complete physical examination by a licensed physician, physician assistance or nurse practitioner for each student prior to or upon first entry into the public school system and also for student transferring into the public system.

RSA 200:141-C The immunizations listed below must be completed prior to school entry:

Varicella	**K-6th Grade** 2 doses *(Varicella vaccine or laboratory diagnosis of chicken pox disease required)*	**7th-12th Grade** 2 doses*(Varicella Vaccination or history of chicken pox disease)*
DTaP **DT/DTP** **Td/Tdap**	**6 years and under:** 4 or 5 doses, with the last dose given on or after the 4th birthday. **7 years and older:** 3 or 4 doses, with the last dose given on or after the 4th birthday. **11 years and older:** A one-time dose of **Tdap** when more than 5 years have passed since the last tetanus toxoid containing vaccine; then boost with **Td** every 10 years. If child turns 11 on or after the first day of school, they are required to have Tdap prior to the first day of the **next** school year.	
Polio	**K-3rd Grade:** 3-4 doses with one dose on or after age four and the last two doses separated by 6 months. **4th-12th Grade:** 3 doses, with the last dose given on or after the 4th birthday. OR 4 doses regardless of age at administration.	
MMR	**K-12th Grade:** 2 doses required, at least one on or after the first birthday.	
Hepatitis B	**K-12th Grade:** 3 doses at acceptable intervals	

IMMUNIZATION	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5
DTaP/Tdap					
HIB					
Polio (IPV or OPV) *Please specify*					
Hep B					
Varivax					
MMR					
Hep A					

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PHYSICIAN'S REPORT OF SCHOOL HEALTH EXAMINATION

Name of Student _____ DOB_____Grade_____

Developmental History:

*Gross Motor:*_____

Fine Motor: _____

*Language Skills:*_____

Physical Examination:

Height:_____ Weight:_____ BMI:_____ Blood Pressure:_____

Vision:_____Hearing:_____

Medication(s):_____
_____
_____

Allergie(s):_____
_____
_____

Is this Child capable of carrying on a full program of school, including Physical Education and sports?

YES___ NO___ If not, please explain:_____

_____

DATE OF EXAM_____ PHYSICIAN'S SIGNATURE:_____

TODAY'S DATE_____ PHYSICIAN'S PRINTED NAME:_____