



Holy Cross School
Dover, Delaware

Child's Name:		Date:	
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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: _____ Weight: _____ BMI: _____ BMI Percentile: _____ BP: _____ Pulse: _____ Other: _____ (inches) (pounds)									
Dental Screen	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care									
Tuberculosis	<p align="center">All new enterers must have TB test or TB Risk Assessment, which must be done within 12 months prior to school entry.</p> <table style="width:100%; border: none;"> <tr> <td style="width: 30%; border: none;">Risk Assessment:</td> <td style="width: 20%; border: none;">Date: _____</td> <td style="width: 50%; border: none;">Results: <input type="checkbox"/> At-Risk <input type="checkbox"/> No Risk</td> </tr> <tr> <td style="border: none;">Mantoux Skin Test:</td> <td style="border: none;">Date: _____</td> <td style="border: none;">Results: _____MM</td> </tr> <tr> <td style="border: none;">Other: (type) _____</td> <td style="border: none;">Date: _____</td> <td style="border: none;">Results: _____MM</td> </tr> </table>	Risk Assessment:	Date: _____	Results: <input type="checkbox"/> At-Risk <input type="checkbox"/> No Risk	Mantoux Skin Test:	Date: _____	Results: _____MM	Other: (type) _____	Date: _____	Results: _____MM
Risk Assessment:	Date: _____	Results: <input type="checkbox"/> At-Risk <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ Vision: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ Other: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____									

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: _____