The Boys' Latin School of Maryland
Assessment of Student Health

822 W. Lake Ave Baltimore, Maryland 21210
Nurse: 410-377-5192 x1136 Fax: 410-377-8770

***Physical Form MUST be turned into the Health Room by August 1, 2017.**

Grade Level (Please circle): K P1 1 2 3 4 5 6 7 8 9 10 11 12

Student Information (This section to be filled out by Parent)

Student Name:_____ **Birth Date:**_____**Phone (H)**_____
Student Address:_____ **City:**_____ **Zip Code:**_____

Parent/Guardian #1 Contact:
Name:_____**Relationship:**_____**Email:**_____
Home phone:_____ **Work phone:**_____ **Cell phone:**_____)_____

Physical Examination (This section to be filled out by Physician)
Height:_____ Weight:_____ B/P:_____ Pulse:_____

MEDICATION
List ANY Medication (for any reason) taken at HOME or at SCHOOL In the event of an emergency, it is imperative that we have all medication history.

Medication:_____**Dosage:**_____**Medication:**_____**Dosage:**_____

Does the student have any allergies? YES NO
Does the student require **EMERGENCY MEDICATION** while at school? YES NO Epipen? Inhaler?
If yes, please explain _____
If Yes to Areas of Concern, list findings below:

Area of Concern	Yes	No	Area of Concern	Yes	No	Area of Concern	Yes	No
Head			Concussions			ADD/ADHD		
Eyes			Skin Acne, Infections			Learning Disabilities		
ENT			Endocrine			Depression/Anxiety		
GI-Celiac, IBS			Bleeding Disorders			Behavior		
Respiratory, Asthma			Immunodeficiency			Headaches, Migraines		
Cardiac			Musculoskeletal-Fractures			History of Fainting		

Findings:_____

Any restrictions on physical activity? _____

This student is cleared for ALL sports/physical education? YES NO

Please specify below any OTC medicine that can be given under nursing discretion while in school or on field trips, including overnight field trips.

Medication	Yes	No	Medication	Yes	No
Ibuprofen			Tums		
Acetaminophen			Maalox		
Benadryl			Visine Eye Drops		
Sudafed PE			Cortisone Cream		
Robitussin DM			Antibiotic Ointment		
Throat Lozenges			Allegra 60 mg		
Allegra 180 mg					

Physician Signature _____**Date** _____

I hereby give permission for my son to receive any medication listed above as deemed necessary by the school nurse and will be administered in accordance with established procedures. I have selected those medications I wish to be made available to my son. I understand that generic equivalent medications may be used in place of more expensive brand name items.

Parent Signature _____**Date** _____

MARYLAND STATE
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) _____ including the summer session.

School: _____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

* Prescription medication must be in a container labeled by the pharmacist or prescriber.
* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school.
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(Type or print)
Telephone: _____ FAX: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): _____ for the above medication on (Date): _____

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: _____
Signature Date

School RN approval for self carry/self administration of emergency medication: _____
Signature Date

Order reviewed by the school RN: _____
Signature Date

2004

The Boys' Latin School of Maryland

Dear Parent or Guardian,

Beginning in the 2014-2015 school year, there are new immunization requirements for children entering kindergarten and 7th grade.

- All students entering kindergarten must have had TWO varicella vaccinations
- All students entering 7th grade must have had one Tdap vaccination and one meningococcal vaccination

These new requirements are in addition to the existing school immunization requirements.

According to Maryland School Immunization Regulations (COMAR 10.06.04), to be allowed in school, students must be immunized according to the *Maryland Recommended Childhood Immunization Schedule*. A child has up to **20 days** from the start of school to show proof of vaccinations or that they have started a plan to get the missing immunizations.

You should work with your child's doctor to get his/her immunization record or the vaccinations that are missing. If you are unable to get an immunization appointment with your child's health care provider, call your local health department.

If you have questions about immunizations that are required for school, please call your child's doctor or the school nurse.

Sincerely,

Barbara Anne Bruno BSN, RN
Boys' Latin School of Maryland

MARYLAND
Department of Health and Mental Hygiene

Vaccine Requirements For Children
Enrolled in Preschool Programs and in Schools — Per DHMH COMAR 10.06.04.03
Maryland School Year 2014 - 2015 (Valid 9/1/14 - 8/31/15)

Required cumulative number of doses for each vaccine for PRESCHOOL aged children enrolled in educational programs

Vaccine / Current Age of Child	DTaP/DTP/DT[1]	Polio[2]	Hib[3]	Measles,[2,4] Mumps, Rubella	Varicella[2,4,5] (Chickenpox)	Hepatitis B	PCV[3] (Prevnar™)
Less than 2 months	0	0	0	0	0	1	0
2 - 3 months	1	1	1	0	0	1	1
4 - 5 months	2	2	2	0	0	2	2
6 - 11 months	3	3	2	0	0	3	2
12 - 14 months	3	3	At least 1 dose given after 12 months of age	1	1	3	2
15 - 23 months	4	3	At least 1 dose given after 12 months of age	1	1	3	2
24—59 months	4	3	At least 1 dose given after 12 months of age	1	1	3	1
60 - 71 months	4	3	0	2	1	3	0

Required cumulative number of doses for each vaccine for children enrolled in KINDERGARTEN - 12th grade

Grade	Grade Level (Ungraded)	DTaP/DTP/Tdap/DT/Td[1,6]	Tdap[6]	Polio[2]	Measles,[2,4] Mumps, Rubella	Varicella[2,4,5] (Chickenpox)	Hepatitis B	Meningococcal
Kindergarten	(5 yrs)	4		3	2	2 (NEW)	3	
Grades 1 - 6	(6 - 11 yrs)	4 or 3		3	2	1 or 2	3	
Grade 7	(11-12 yrs)	3	1 (NEW)	3	2	1 or 2	3	1 (NEW)
Grades 8-12	(12-18+ yrs)	3		3	2	1 or 2	3	

*** See footnotes on back for NEW Requirements for 2014-15 school year.**

Vaccine Requirements For Children
Enrolled in Preschool Programs and in Schools
Maryland School Year 2014 - 2015 (Valid 9/1/14 - 8/31/15)

FOOTNOTES

NEW Requirements for the 2014-15 school year are:

- **2 doses of Varicella vaccine for entry into Kindergarten**
- **1 dose of Tdap vaccine for entry into 7th grade**
- **1 dose of Meningococcal vaccine for entry into 7th grade**

1. If DT vaccine is given in place of DTP or DTaP, a physician documented medical contraindication is required.
2. Proof of immunity by positive blood test is acceptable in lieu of vaccine history for hepatitis B, polio and measles, mumps, rubella and varicella.
3. Hib and PCV(Prevnar^{TM}) are not required for children older than 59 months (5 years) of age.
4. All doses of measles, mumps, rubella and varicella vaccines should be given on or after the first birthday. However, upon record review for students in preschool through 12th grade, a preschool or school may count as valid vaccine doses administered less than or equal to four (4) days before first birthday.
5. One dose of varicella (chickenpox) is required for a student younger than 13 years old. Two doses of varicella vaccine are required for students entering Kindergarten and for previously unvaccinated students 13 years of age or older. Medical diagnosis of varicella disease is acceptable in lieu of vaccination. Medical diagnosis is documented history of disease provided by a physician or health care provider. Documentation must include month and year. In the absence of documentation a medical provider or local health department may verify immunity via blood test, **but revaccination may be more expedient.**
6. Four (4) doses of DTP/DTaP are required for children less than 7 years old. Three (3) doses of tetanus and diphtheria containing vaccine (any combination of the following — DTP, DTaP, Tdap, DT or Td) are required for children 7 years of age and older. One dose of Tdap vaccine received prior to entering 7th grade is acceptable and should be counted as a dose that fulfills the 7th grade Tdap requirement.

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME_____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP_____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease
1									1				Mo/Yr
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4										_____	_____	_____	_____
5										_____	_____	_____	_____
										_____			

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name
Office Address/ Phone Number

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the DHMH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and DHMH COMAR 10.06.04.03 are available at www.dhmh.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.dhmh.maryland.gov. (Choose Immunization in the A-Z Index)