NEWFIELDS ELEMENTARY SCHOOL
9 Piscassic Road
Newfields, NH 03856
(603)772-5555

Dennis Dobe, Principal

To the Parents of Newfields Kindergarten, First Grade or Transfer Students:

HEALTH RECORD for ____

Date of Birth____________Sex _____ Parents/Guardians ______________________________

THE NEW HAMPSHIRE STATE LAW REQUIRES:

RSA 200:32 A complete medical examination by a licensed physician upon or prior to entrance into a public school system and thereafter as often as deemed necessary by the local school authority.

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

1) **MMR** (measles, mumps, rubella) - one dose of MMR given on or after the 12 month birthday. A second measles vaccine is required prior to children entering kindergarten or 1st grade for the 2003/2004

2) **Polio Vaccine** (IPV/OPV) - 4 doses will be acceptable regardless of the age of administration. 3 doses of an **all** eIPV or **all** OPV schedule will be acceptable as long as one dose was administered after the 4th birthday. If a combination has been administered all 4 are needed.

3) **Diptheria, Pertussis and Tetanus** (DPT) A minimum of 4 doses of DTP, DTaP, DT, or TD, as long as last dose is after age 4. (Adult type TD when child is over six years of age) or 5 doses regardless of age.

4) **Hepatitis B Vaccine** (Hep B) - a minimum of 3 doses for children born on or after January 1, 1993. Third dose administered at age 6 months or older with 28 days between doses 1 and 2 and 2 months between doses 2 and 3 with at least 4 months between 1 and 3.

5) **Varicella Vaccine** - 1 Dose or parent record of the disease.

IMMUNIZATIONS					
Administration dates (MM/DD/YY)					
Immunization	1	2	3	4	5
DTP/DTaP/DT/TD					
HIB					
Polio (eIPV)					
Polio (OPV)					
Hep B					
Varivax					
MMR					

*** For all minimum intervals and age requirement, please access the Health Services section of the SAU Web Site at: http://www.sau16.org/aboutus/health/immunreq.htm**

PLEASE COMPLETE BOTH SIDES OF THIS FORM

PHYSICIAN'S REPORT OF SCHOOL HEALTH EXAMINATION

Name of Pupil ______________________________ Grade __________

DEVELOPMENTAL HISTORY: Estimate of Functional Capacity

	Advanced for Developmental Phase	Consistent with Developmental Phase	Delayed for Developmental Phase
Gross Motor			
Fine Motor			
Language Skills			

PHYSICAL EXAMINATION

Height ______________________________

Weight ______________________________

Nutrition ______________________________

General Body Type (Describe as tall & thin, short & heavy, etc.)

____

Posture: (remark on presence or absence of scoliosis and lordosis and define scoliosis as functional or organic)

____

Skin ______________________________

Vision ______________________________

Hearing:

Audiogram ______________________________

Tympanogram ______________________________

Nose ______________________________

Mouth ______________________________

Teeth ______________________________

Pharnyx ______________________________

Thyroid ______________________________

Lymph Glands ______________________________

Lungs ______________________________

Blood Pressure ______________________________

Pulse Rate ______________________________

Abdomen ______________________________

Hernia ______________________________

Genitalia ______________________________

Skeleton ______________________________

Feet ______________________________

Reflexes ______________________________

(If deemed necessary by examiner)

Allergies ______________________________

Medication ______________________________

Is this child capable of carrying a full program of schoolwork including gymnastics and athletics?
_______YES _______No If not, please explain:

REMARKS AND RECOMMENDATIONS

____
Date of Exam

____
Today's Date

____
Physician's Signature

____
Printed Physician Name