

**STRATHAM MEMORIAL SCHOOL**  
**39 Gifford Farm Road**  
**Stratham, NH 03885 (603)772-5413**

Tom Fosher, Principal

Judy Lewis, R.N.  
 Annemarie Peck, Asst.

To the Parents of Stratham Kindergarten Children 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.
- 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) **Diphtheria, 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.

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

**\* FOR ALL MINIMUM INTERVALS AND AGE REQUIREMENTS PLEASE ACCESS THE SCHOOL WEBSITE  
 AT: <http://www.sau16.org>**

**\*\*PLEASE COMPLETE BOTH SIDES OF THIS FORM\*\***

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PHYSICIAN'S REPORT OF SCHOOL HEALTH EXAMINATION

Name of Pupil \_\_\_\_\_ Grade \_\_\_\_\_

**DEVELOPMENTAL HISTORY: Estimate of Functional Capacity**

	Advanced for Developmental Phase	Consistent for Development Phase	Delayed for Dev. 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 _____	Pharynx _____ Thyroid _____ Lymph Glands _____ Lungs _____ Blood Pressure _____ Pulse Rate _____ _____ Abdomen _____ Hernia _____ Genitalia _____ Skeleton _____ Feet _____ Reflexes _____ (If deemed necessary by examiner) Allergies _____ Medication _____
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Is this child capable of carrying a full program of school work including gymnastics and athletics? If not, please explain. Yes \_\_\_\_\_ No \_\_\_\_\_

REMARKS AND RECOMMENDATIONS:

DATE OF EXAM \_\_\_\_\_ PHYSICIAN'S SIGNATURE \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_ PRINTED PHYSICIAN'S NAME \_\_\_\_\_

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