# SCHOOL VACCINATION REQUIREMENTS
## FOR ATTENDANCE IN PENNSYLVANIA SCHOOLS

## FOR ATTENDANCE IN ALL GRADES CHILDREN NEED THE FOLLOWING:

- 4 doses of tetanus, diphtheria, and acellular pertussis* (1 dose on or after the 4th birthday)
- 4 doses of polio (4th dose on or after 4th birthday and at least 6 months after previous dose given)**
- 2 doses of measles, mumps, rubella***
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox) or evidence of immunity

**Usually given as DTP or DTaP or if medically advisable, DT or Td*
*** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose*
****Usually given as MMR*

**ON THE FIRST DAY OF SCHOOL,** unless the child has a medical or religious/philosophical exemption, a child must have had at least one dose of the above vaccinations or risk exclusion.

- If a child does not have all the doses listed above, needs additional doses, and the next dose is medically appropriate, the child must receive that dose within the first five days of school or risk exclusion. If the next dose is not the final dose of the series, the child must also provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.
- If a child does not have all the doses listed above, needs additional doses, and the next dose is not medically appropriate, the child must provide a medical plan (red and white card) within the first five days of school for obtaining the required immunizations or risk exclusion.
- The medical plan must be followed or risk exclusion.

## FOR ATTENDANCE IN 7TH GRADE:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) on the first day of 7th grade.
- 1 dose of meningococcal conjugate vaccine (MCV) on the first day of 7th grade.

**ON THE FIRST DAY OF 7TH GRADE,** unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

## FOR ATTENDANCE IN 12TH GRADE:

- 1 dose of MCV on the first day of 12th grade. If one dose was given at 16 years of age or older, that shall count as the twelfth grade dose.

**ON THE FIRST DAY OF 12TH GRADE,** unless the child has a medical or religious/philosophical exemption, a child must have had the above vaccines or risk exclusion.

**The vaccines required for entrance, 7th grade and 12th grade continue to be required in each succeeding school year.**

These requirements allow for the following exemptions: medical reason, religious belief, or philosophical/strong moral or ethical conviction. Even if your child is exempt from immunizations, he or she may be excluded from school during an outbreak of vaccine preventable disease.

Pennsylvania's school immunization requirements can be found in 28 Pa.CODE CH.23 (School Immunization). Contact your healthcare provider or call 1-877-PA-HEALTH for more information.

pennsylvania
DEPARTMENT OF HEALTH

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Bureau of Community Health Systems
Division of School Health

# Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

**PARENT / GUARDIAN / STUDENT:**
**Complete page one of this form before student's exam. Take completed form to appointment.**

Student's name _____ Today's date_____

Date of birth _____ Age at time of exam_____ Gender: ☐ Male ☐ Female

**Medicines and Allergies:** Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

**Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.**

| **GENERAL HEALTH:** ***Has the student…*** | **YES** | **NO** |
|---|---|---|
| 1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____ | | |
| 2. Ever stayed more than one night in the hospital? | | |
| 3. Ever had surgery? | | |
| 4. Ever had a seizure? | | |
| 5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ? | | |
| 6. Ever become ill while exercising in the heat? | | |
| 7. Had frequent muscle cramps when exercising? | | |
| **HEAD/NECK/SPINE:** ***Has the student…*** | **YES** | **NO** |
| 8. Had headaches with exercise? | | |
| 9. Ever had a head injury or concussion? | | |
| 10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling? | | |
| 12. Ever been unable to move arms or legs after being hit or falling? | | |
| 13. Noticed or been told he/she has a curved spine or scoliosis? | | |
| 14. Had any problem with his/her eyes (vision) or had a history of an eye injury? | | |
| 15. Been prescribed glasses or contact lenses? | | |
| **HEART/LUNGS:** ***Has the student...*** | **YES** | **NO** |
| 16. Ever used an inhaler or taken asthma medicine? | | |
| 17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____ | | |
| 18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)? | | |
| 19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **DURING** or **AFTER** exercise? | | |
| 20. Had discomfort, pain, tightness or chest pressure during exercise? | | |
| 21. Felt his/her heart race or skip beats during exercise? | | |
| **BONE/JOINT:** ***Has the student...*** | **YES** | **NO** |
| 22. Had a broken or fractured bone, stress fracture, or dislocated joint? | | |
| 23. Had an injury to a muscle, ligament, or tendon? | | |
| 24. Had an injury that required a brace, cast, crutches, or orthotics? | | |
| 25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury? | | |
| 26. Had joints that become painful, swollen, feel warm, or look red? | | |
| **SKIN:** ***Has the student…*** | **YES** | **NO** |
| 27. Had any rashes, pressure sores, or other skin problems? | | |
| 28. Ever had herpes or a MRSA skin infection? | | |

| **GENITOURINARY:** ***Has the student…*** | **YES** | **NO** |
|---|---|---|
| 29. Had groin pain or a painful bulge or hernia in the groin area? | | |
| 30. Had a history of urinary tract infections or bedwetting? | | |
| 31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____ | | |
| **DENTAL:** | **YES** | **NO** |
| 32. Has the student had any pain or problems with his/her gums or teeth? | | |
| 33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years | | |
| **SOCIAL/LEARNING:** ***Has the student…*** | **YES** | **NO** |
| 34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.? | | |
| 35. Been bullied or experienced bullying behavior? | | |
| 36. Experienced major grief, trauma, or other significant life event? | | |
| 37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends? | | |
| 38. Been worried, sad, upset, or angry much of the time? | | |
| 39. Shown a general loss of energy, motivation, interest or enthusiasm? | | |
| 40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight? | | |
| 41. Used (or currently uses) tobacco, alcohol, or drugs? | | |
| **FAMILY HEALTH:** | **YES** | **NO** |
| 42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other_____ | | |
| 43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_____ | | |
| 44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning? | | |
| 45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)? | | |
| **QUESTIONS OR CONCERNS** | **YES** | **NO** |
| 46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.) | | |

**I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.**

Signature of parent / guardian / emancipated student_____ Date_____

**STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐**

| **Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐** | **CHECK ONE** | | | ***ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS** |
|---|---|---|---|---|
| | **NORMAL** | ***ABNORMAL** | **DEFER** | |
| Height: ( ) inches | | | | |
| Weight: ( ) pounds | | | | |
| BMI: ( ) | | | | |
| BMI-for-Age Percentile: ( ) % | | | | |
| Pulse: ( ) | | | | |
| Blood Pressure: ( / ) | | | | |
| Hair/Scalp | | | | |
| Skin | | | | |
| Eyes/Vision Corrected ☐ | | | | |
| Ears/Hearing | | | | |
| Nose and Throat | | | | |
| Teeth and Gingiva | | | | |
| Lymph Glands | | | | |
| Heart | | | | |
| Lungs | | | | |
| Abdomen | | | | |
| Genitourinary | | | | |
| Neuromuscular System | | | | |
| Extremities | | | | |
| Spine (Scoliosis) | | | | |
| Other | | | | |

| **TUBERCULIN TEST** | **DATE APPLIED** | **DATE READ** | **RESULT/FOLLOW-UP** |
|---|---|---|---|
| | | | |
| | | | |

**MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION**

**(Additional space on page 4)**

**Parent/guardian present during exam: Yes ☐ No ☐**

**Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____**

**Print name of examiner** _____

**Print examiner's office address**_____ **Phone**_____

**Signature of examiner**_____ **MD ☐ DO ☐ PAC ☐ CRNP ☐**

**STUDENT NAME:**

**HEALTH CARE PROVIDERS:** ***Please photocopy immunization history from student's record – OR – insert information below.***

**IMMUNIZATION EXEMPTION(S):**

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

**NOTE:** The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

| VACCINE | DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization | | | | |
|---|---|---|---|---|---|
| Diphtheria/Tetanus/Pertussis (child)<br>Type: DTaP, DTP or DT | 1 | 2 | 3 | 4 | 5 |
| Diphtheria/Tetanus/Pertussis (adolescent/adult)<br>Type: Tdap or Td | 1 | 2 | 3 | 4 | 5 |
| Polio<br>Type: OPV or IPV | 1 | 2 | 3 | 4 | 5 |
| Hepatitis B (HepB) | 1 | 2 | 3 | 4 | 5 |
| Measles/Mumps/Rubella (MMR) | 1 | 2 | 3 | 4 | 5 |
| Mumps disease diagnosed by physician ☐ | Date:_____ | | | | |
| Varicella: Vaccine ☐ Disease ☐ | 1 | 2 | 3 | 4 | 5 |
| Serology: (Identify Antigen/Date/POS or NEG)<br>i.e. Hep B, Measles, Rubella, Varicella | 1 | 2 | 3 | 4 | 5 |
| Meningococcal Conjugate Vaccine (MCV4) | 1 | 2 | 3 | 4 | 5 |
| Human Papilloma Virus (HPV)<br>Type: HPV2 or HPV4 | 1 | 2 | 3 | 4 | 5 |
| Influenza<br>Type: TIV (injected)<br>LAIV (nasal) | 1 | 2 | 3 | 4 | 5 |
| | 6 | 7 | 8 | 9 | 10 |
| | 11 | 12 | 13 | 14 | 15 |
| Haemophilus Influenzae Type b (Hib) | 1 | 2 | 3 | 4 | 5 |
| Pneumococcal Conjugate Vaccine (PCV)<br>Type: 7 or 13 | 1 | 2 | 3 | 4 | 5 |
| Hepatitis A (HepA) | 1 | 2 | 3 | 4 | 5 |
| Rotavirus | 1 | 2 | 3 | 4 | 5 |
| **Other Vaccines: (Type and Date)** | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

 **ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)**
**STUDENT NAME:**