Tredyffrin/Easttown School District

Student Health Services

The Pennsylvania School Health Act requires that all children entering Pennsylvania Schools meet the following requirements. **PLEASE NOTE:** These state requirements have changed effective 8/1/17.

1. **Immunizations** – Proof of these required immunizations must be provided at the time of registration.

Children in **All** grades (K-12) need the following vaccines:

- 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 and rubella ** (given after 12 months)
- 3 doses of hepatitis B
- 2 doses of varicella (chickenpox- vaccine given after 12 months) or history of the disease

Children 7th-12th Grade –ADDITIONAL immunization requirements for attendance:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap)

- 2 doses meningococcal conjugate vaccine (MCV)
  -1st dose given 11-15 years of age; a second dose is required at age 16 or entry into 12th grade.
  - If the dose was given at 16 years of age or older, only one dose is required.

* Usually given as DTaP, DTP, DT, Td
** Usually given as MMR

2. **Physical Examination report** consistent with Pennsylvania requirements; upon original entry, grade 6 and grade 11.

3. **Dental examination** for all students upon original entry, grade 3 and grade 7.

TREDYFFRIN/EASTTOWN SCHOOL DISTRICT

Physical Examination Report

Name _____ **Sex** ____ **Birthdate** _____ **Grade** ____

Immunizations	Dates Given				
Diphtheria, Pertussis, Tetanus DTap, DTP, DT, Td					
Tdap					
Polio					
Hepatitis B (indicate if 2 dose series)					
Measles - Mumps - Rubella (MMR)					
Meningococcal (MCV)					
HPV					
Other					

Chicken Pox disease _____ Varicella immunization dates_____ _____

TB Test Date _____ Results _____

Allergies:

Significant Past Medical History:

Current Medications:

Current Physical Findings: **Date of Current Exam:** _____

- Height: _____ Weight: _____ BMI: _____ Blood Pressure: _____ Pulse:_____

  Recommendation if abnormal _____

- Scoliosis: Normal ___ Abnormal ____Degree of Curve if abnormal _____

  Recommendation if abnormal _____

- Explain any problem of vision, hearing, or speech which requires special seating or follow-up with therapist or school nurse:

- Explain any condition which limits mobility, endurance, or physical education:

Please print or stamp

Physicians Name: Physicians Signature:_____

Address:

Phone: Date: _____