CESJDS
CHARLES E SMITH JEWISH DAY SCHOOL
בית מדרש צוריאל

Dear Parents,

All students entering Kindergarten and 7th Grade, and all students new to the school, are required to complete and return the enclosed Physical Exam and Health Inventory Forms. This form has three parts:

Part 1 - Health history to be completed by parent
Part 2 - Physical exam to be completed by physician
Part 3 - Immunization record required by the State of Maryland

Please read the cover page of this packet. The State requires that all immunizations be completed before the child begins school. In addition, children entering school from outside the country are required to have a tuberculosis skin test (PPD) done in the United States before the start of school. If you have any questions, please contact the school nurse. **It is advisable to keep a copy of the completed health forms, including the immunization form, for your records before submitting to the school.**

During the physician's exam, make sure that your physician notes the request for vision, hearing and scoliosis screenings. If your child has any vision problems, update eyeglasses during the summer, before the school year begins.

Thank you,

Mary Goldstein, RN – Lower School Nurse
Margarita Rosado-Payne, RN – Upper School Nurse

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Grade: _____

2015-2016 School Physical Exam and Health Inventory

(confidential use only)

Child's Name _____ _____ _____ Birth Date _____

(Last) (First) (Middle)

Parent/Guardian _____

Home Address _____

City, State, Zip _____

Home Telephone _____ Cell Phone _____

Immunization requirements for the school year:

DPT/DT	4 doses for children 7 years and younger (3 doses over 8 years)
Polio	3 doses
Measles	2 doses at one year of age or after
Mumps	1 dose at one year of age or after
Rubella	1 dose at one year of age or after
Varicella	1 dose at one year of age or after for all children entering grades 1-11; 2 doses required for students entering Kindergarten
Hepatitis B	3 doses for all children entering grades K-11
TB Skin Test	PPD for all children entering school from outside the United States; must be completed in the U.S. before admission to school
Tdap and Meningococcal	1 dose each required for students entering 7th grade

Please complete and return all forms to your child's campus by the first week in August.

Send to: Charles E. Smith Jewish Day School
Lower School: 1901 E. Jefferson St., Rockville, MD 20852
Upper School: 11710 Hunters Lane, Rockville, MD 20852
Attention: School Nurse

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Student Name: _____ Grade: _____

Part I: To be completed by Parent/Guardian

Please circle the appropriate answers to the questions below. Explain "yes" answers.

1.	Has your child ever been treated for a serious health problem? (Heart, kidney, diabetes, blood disorder, cancer, seizures, etc.)	YES	NO
2.	Has your child been diagnosed with an anaphylactic allergy?	YES	NO
3.	Has your child had asthma or needed an inhaler for difficulty breathing?	YES	NO
4.	Does your child have vision problems or use eyeglasses? Date of last eye exam_____	YES	NO
5.	Does your child have hearing or speech problems?	YES	NO
6.	Has your child been treated for emotional problems such as depressions, ADD, eating disorders, obsessive behavior, or any other?	YES	NO
7.	Is your child now, or within the last three years, on any daily medications?	YES	NO
8.	Does your child have any recurrent complaints? (Headaches, stomachaches, insomnia, dizziness, etc.)	YES	NO
9.	Does your child have any bathroom accidents? (1) Urine _____times daily _____ times weekly (2) Bowel Movement _____ times daily _____ times weekly	YES	NO

Please elaborate below (and on reverse side) any YES responses, or to explain about any other health issues.

_____

_____

_____

Everything I have stated is correct and complete. If there are any changes in my child's health or medications, I will notify the school nurse. I give permission to the physician to complete Part II of this form for confidential use in meeting my child's health and educational needs in school.

***Parent/Guardian Signature _____ Date _____**

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Part II: Medical Evaluation

To be completed by physician

Grade: _____

Date of Physical: _____

Name _____ **Date of Birth** _____/_____/_____ **Sex**_____
(Last) (First) (Middle) (Mo)(Date)(Yr)

Dates of Most Recent: TB Skin _____

Height _____ Weight _____ BP _____ Resting HR _____ Hearing R _____ L _____

Vision (w/o glasses) R 20/_____ L 20/_____ (with glasses) R 20/_____ L 20/_____ Color Vision _____

Allergies (e.g. hay fever, adhesive tape, insect stings, drugs)

_____

Could this student require emergency action while at school (e.g. seizure, insect stings, allergy, bleeding conditions, diabetes, heart conditions)? _____ If YES, please describe:

_____

_____

Any current medical conditions (e.g. exercise-induced asthma, ADD, emotional problems)? _____ If YES, please describe:_____

_____

Any medication taken regularly? _____ If YES, name of medication and dose_____

PHYSICAL EXAMINATION

SYSTEM	DATE EXAMINED	COMMENTS
Appearance, nutrition, skin		
Posture, gait, spine (Scoliosis)		
Ears, nose, throat, eyes, mouth, teeth		
Cardiovascular (chest, neck, heart, lungs)		
Abdomen, genitalia, hernia, sexual maturity		
Orthopedic (bones, joints, muscles)		
Neurological		
Other		

Any limitation of physical activities (e.g., running/contact sports)? _____ If YES, please describe:

_____

_____

Any known orthopedic injury or condition? _____ If YES, please describe: _____

_____

**** Is this student capable of unlimited participation in all school activities? _____**

If NO, please specify:

_____

SIGNED _____ DATE _____

(Examining physician)

PHYSICIAN'S NAME: _____ PHONE _____

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-Td-Tdap Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Heb B Mo/Day/Yr	PCV7 Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV4 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										Other _____	Other _____	Other _____	Other _____
4													
5													

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

Office Stamp

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.

LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: _____ Date: _____
Parent or Guardian

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

MEDICAL CONTRAINDICATION:

The above child has a valid medical contraindication to being immunized at this time.

This is a ☐ permanent condition ☐ temporary condition until _____/_____/_____

Check appropriate box, indicate vaccine(s) and reasons: _____

Signed: _____ Date _____
Physician or Health Officer

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 immunizations 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 directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, per 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; and (h) Varicella."

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.EDCP.org (Immunization).

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.14.02.44 and COMAR 13A.14.01.29 DHR COMAR and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.EDCP.org (Immunization).