HOLY GHOST PREPARATORY SCHOOL
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Pennsylvania School Immunization Requirements

The Pennsylvania Department of Health is changing school immunization regulations beginning in August 2017. The regulations are intended to ensure that children attending school in the commonwealth are adequately protected against potential outbreaks of vaccine preventable diseases.

The Pennsylvania Department of Health now requires the following immunizations for entry into school and continued attendance.

Children in ALL grades (K-12) need the following immunizations for attendance:

- 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
**Usually given as MMR

Children in 7th-grade need the following additional immunizations for attendance:

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap)
- 1 dose meningococcal conjugate vaccine (MCV)

Children by 12th-grade need the following additional immunizations for attendance:

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

Exemptions to school laws for immunizations are:

- medical reasons;
- religious beliefs; and
- philosophical/strong moral or ethical conviction

If your child is exempt from immunizations, he may be removed from school during an outbreak.

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

H511.336 (Rev. 5/02)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

DATE _____ 20 ____

NAME OF SCHOOL Holy Ghost Prep. H.S GRADE ____ HOMEROOM ____

NAME OF CHILD	DATE OF BIRTH	SEX
Last First Middle		☐ M ☐ F

ADDRESS

No. and Street City or Post Office Borough or Township County State Zip Code

PENNSYLVANIA DEPARTMENT OF HEALTH – CERTIFICATE OF IMMUNIZATION

VACCINE Circle appropriate item	Enter month, day, and year when immunization doses listed below were given.				
Diphtheria, tetanus and acellular pertussis (DTaP, DTP, Td or DT)	1 / /	2 / /	3 / /	4 / /	5 / /
Tetanus, diphtheria and acellular pertussis (Tdap)	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (OPV or IPV)	1 / /	2 / /	3 / /	4 / /	5 / /
Hepatitis B	1 / /	2 / /	3 / /	4 / /	5 / /
Measles - mumps - rubella (MMR)	1 / /	2 / /	or Measles serology Date	Titer	
Varicella (vaccine or disease)	1 / /	2 / /	Rubella serology	Date	Titer
Meningococcal (MCV)	1 / /	2 / /			
Other	1 / /	2 / /	Mumps disease diagnosed by a physician: Date		

H502.320 Rev. 03/17

[illegible] and requires a written statement from the parent/guardian)

If Applicable:

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	**Results (mm)**		**Signature**		

Follow-Up of significant tuberculin tests:

Parent/Guardian notified of significant findings on. _____ Date

Result of Diagnostic Studies: _____ Date

Preventive Anti-Tuberculosis - Chemotherapy ordered. ☐ No ☐ Yes _____ Date

(Continued on Back)

Significant Medical Conditions

	Yes	No	If Yes, Explain
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

Report of Physical Examination

• Height (inches)				
• Weight (pounds) BMI				
• Pulse ( )				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes/Vision				
• Ears/Hearing				
• Nose and Throat				
• Teeth and Gingiva				
• Lymph Glands				
• Heart — Murmur, etc.				
• Lung — Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

_____
Date of Examination

_____
Signature of Examiner

_____
Print Name of Examiner

_____
Address

_____
Telephone Numbe