

WMS STUDENT HEALTH APPRAISAL FORM

Name: _____ Gender: _____ DOB: _____

IMMUNIZATIONS

Entire section below to be completed by MD/DO/APN/NP/PA
 Printed VAR form may be attached in lieu of completion.

Immunizations – Shaded Vaccines Required. Regulations is located at Title 14 Section 804 Immunizations

DTaP/ DT	DTaP/ DT	DTaP/ DT	DTaP/ DT	DTaP/ DT
OPV/ IPV	OPV/ IPV	OPV/ IPV	OPV/ IPV	OPV/ IPV
PCV7/ PCV13	PCV7/ PCV13	PCV7/ PCV13	PCV7/ PCV13	PCV7/ PCV13
Hib	Hib	Hib	Hib	
MMR	MMR	HepB /HepB-2	HepB /HepB-2	HepB
VAR	VAR	RV-2/ RV-3	RV-2/ RV-3	RV-3
MCV4	MCV4	HPV	HPV	HPV
Hep A	Hep A	Td/ Tdap	Td/ Tdap	Td
Influenza	Influenza	PPSV23	PPSV23	
Other:	Other:	Other:	Other:	Other:

Is child is fully immunized per DPH/CDC recommendations? (refer to cover page) ☐ Yes ☐ No

SCREENING & TESTING

Entire section below to be completed by MD/DO/APN/NP/PA

Screen	Height: _____ (inches) Weight: _____ (pounds) BMI: _____ BMI Percentile: _____ BP: _____ Pulse: _____ Other: _____
Dental Screen	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care
Tuberculosis Screen	All new enterers must have TB test <u>or</u> TB Risk Assessment, which must be done within 12 months <u>prior</u> to school entry. Risk Assessment: _____ Date _____ Results: <input type="checkbox"/> Test Required <input type="checkbox"/> Test Not Required Mantoux Skin Test: _____ Date _____ Results: _____ MM Other: (type) _____ Date _____ Results: _____ MM
Lead Test	Blood lead test required for children age 6 months through 6 years – one time only Date: _____ Results: _____
Other Screen	Hearing: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Vision: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Other: Type: _____ Date: _____ Results: _____ Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes _____

DATE OF EXAM - *Entire section below to be completed by MD/DO/APN/PA*

PHYSICAL EXAMINATION	Check (✓)			HEALTHCARE PROVIDER COMMENT
	NORMAL	ABNORMAL	REFERRAL	
General Appearance				
Skin				
Eyes				
Ears				
Nose/Throat				
Mouth/Dental				
Cardiovascular				
Respiratory				
Thyroid				
Gastrointestinal				
Genito-Urinary				
Neurological				
Musculoskeletal				
Spinal examination				
Nutritional status				
Mental health status				

FOR CHRONIC & LIFE THREATENING CONDITIONS:Children with life-threatening conditions need an emergency care plan for school.

Please attach care plan, protocols, and/or emergency care plan.

Please provide the parent with information on Special Needs Alert Program (SNAP) for EMS.

Recommendations or Referrals: _____

DIAGNOSIS	EMERGENCY PLAN ATTACHED		CARE PLAN OR PRESCRIPTION PLAN ATTACHED	
	YES	NO	YES	NO

Signature: _____ Date: _____

Print Name: _____

Address: _____

Phone: _____