April 16, 2015

Dear Browning Parents:

Enclosed is the health form for the 2015-2016 academic years. The form must be completed and returned to the Health Office by **August 15, 2015**.

As you are aware, it is a school requirement that a yearly physical examination report be kept on file in the health office. **Without properly completed health forms on file, your son will be unable to begin school in September.**

In addition, a health directive has come from the NYC Department of Health and Mental Hygiene. All students will be required to have Hepatitis B vaccine. One dose of Varicella vaccine is also required for all children through and including Form III. Tdap is required for all children born on or after January 1, 1994 and those entering 6th Grade and above.

Please return the completed form to the attention of Maureen Linehan, RN, School Nurse. **Before returning the form, please make a copy for your file.** Thank you for your cooperation in this important matter.

Required form for returning students is:

1. Family Information Sheet And Physical Examination Form.
2. Complete Immunization History.

Sincerely yours,

Maureen Linehan, RN, BSN, NCSN
校医
HEALTH FORM

September 2015 – June 2016

GRADE ____________________

STUDENT’S NAME ________________________  BIRTH DATE____________

PARENT NAME (PRIMARY CONTACT) ____________________________________________

HOME ADDRESS ___________________________  TEL. NO. _______________

BUSINESS _________________________________  TEL. NO. _______________

CELL NO. _______________

PARENT NAME __________________________________  TEL. NO. _______________

HOME ADDRESS ___________________________  TEL. NO. _______________

BUSINESS _________________________________  TEL. NO. _______________

CELL NO. _______________

CARETAKER NAME _______________________________  CELL NO. _______________

PERSONS TO CONTACT IF UNABLE TO REACH PARENTS

_______________________________________________  TEL. NO. _______________

_______________________________________________  TEL. NO. _______________

I give my permission for the school nurse to administer first-aid if such is needed. In the event that I cannot be reached, and emergency hospital care / treatment is needed, I give permission for my child to be taken to the nearest hospital and given the necessary emergency care.

SIGNATURE OF PARENT/GUARDIAN ____________________________  DATE ______________

The School Nurse May Administer The Following Medications:

__ TYLENOL  __ ADVIL  __ SUDAFED  __ BENADRYL  __ ANTACID  __ ROBITUSSIN  __ CLARITIN

OTHER* ____________________________________________ (NAME AND DOSAGE)

ASTHMA MEDICATION* ___________________________  PEAK FLOW ____________

*Please be advised that any prescription medication must be in a labeled medication bottle from the pharmacy and kept in the Nurse’s office. Any maintenance medication must be accompanied by a Doctor’s order.

SIGNATURE OF PARENT/GUARDIAN ____________________________  DATE ______________
Physical Examination *(To Be Completed Each Year**) *

HEIGHT ________ WEIGHT _______ BMI __________

BLOOD PRESSURE ___________ PULSE __________

LAST DENTAL EXAM ____________

VISION: RIGHT ___________ LEFT ___________

HEARING: TYPE OF TEST ____________ RIGHT ___________ LEFT ___________

ENT ______________________________________________________________________

CARDIOVASCULAR __________________________________________________________

URINALYSIS___________________________________________________________

ABDOMEN ______________________________________________________________

HEMOGLOBIN/HEMATOCRIT ________________________

GENITALIA ______________________________________________________________

EXTREMITIES ___________________________________________________________

MUSCULO-SKELETAL __________________________________________________________________________

SCOLIOSIS CHECK _______________________________________________________

SKIN _________________________________________________________________

MAY THE STUDENT PARTICIPATE IN ALL PHYSICAL ACTIVITY? ______

NEUROLOGICAL _________________________________________________________

EMOTIONAL __________________________________________________________

DENTAL ______________________________________________________________

NUTRITIONAL __________________________________________________________

PAST ILLNESSES, INCLUDING CONTAGIOUS DISEASES ________________________________

OPERATIONS _______________________________________________________________________

SIGNIFICANT FAMILY HISTORY _______________________________________________

SIGNIFICANT CHRONIC PROBLEMS _____________________________________________

MAINTENANCE MEDICATION _________________________________________________

IMMUNIZATIONS DURING THE PAST YEAR _________________________________________

ALLERGIES _______________________________________________________________________

PHYSICIAN’S SIGNATURE_________________________________________ DATE ___________

PHYSICIAN’S STAMP_________________________________________ TELEPHONE ________
THE BROWNING SCHOOL
From the Nurse’s Office

STUDENT’S NAME

DATE OF BIRTH

STUDENT’S GRADE

PLEASE INCLUDE DAY, MONTH AND YEAR OF EACH IMMUNIZATION RECORD

IMMUNIZATION HISTORY

<table>
<thead>
<tr>
<th></th>
<th>1ST</th>
<th>2nd</th>
<th>3RD</th>
<th>4TH</th>
<th>5TH</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DT/DTaP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tdap</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hib</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPV/IPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VARICELLA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MANTOUX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other/Specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PHYSICIAN’S SIGNATURE _______________________________ DATE _______________

PHYSICIAN’S STAMP _______________________________ TELEPHONE _________
Notes: The number of required vaccine doses depends on the schedule recommended by the Advisory Committee for Immunization Practices (ACIP).

This schedule reflects the number of doses required for Pre-K through grade 12. Intervals between doses of vaccine should be in accordance with the ACIP recommended immunization schedule for persons 0 through 18 years of age. See footnotes for specific information for each vaccine.

### FULL COMPLIANCE 2014

<table>
<thead>
<tr>
<th>VACCINES</th>
<th>PRE-KINDERGARTEN (Day Care, Head Start, Nursery or Pre-K)</th>
<th>KINDERGARTEN</th>
<th>GRADES 1 through 5</th>
<th>GRADE 6</th>
<th>GRADES 7 through 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria and Tetanus toxoid-containing vaccine DTaP/DPT/Tdap</td>
<td>4 doses</td>
<td>4 to 5 doses</td>
<td>If the fourth dose of DTaP was administered at age 4 or older, the fifth (booster) dose is not necessary.</td>
<td>4 to 5 doses</td>
<td>3 doses</td>
</tr>
<tr>
<td>Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>1 dose</td>
<td>1 dose</td>
</tr>
<tr>
<td>Polio (IPV/OPV)</td>
<td>3 doses</td>
<td>3 to 5 doses</td>
<td>If 4 or more doses were administered before age 4 years, an additional dose should be received on or after age 4 years. For children 4 years of age or older who have previously received less than 3 doses, a total of 3 doses are required. If both OPV and IPV were administered as part of a series, a total of 4 doses should be received, regardless of the child’s current age.</td>
<td>3 doses</td>
<td>3 to 5 doses</td>
</tr>
<tr>
<td>Measles, Mumps and Rubella (MMR)</td>
<td>1 dose</td>
<td>1 dose</td>
<td></td>
<td>2 doses</td>
<td>2 doses</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>3 doses</td>
<td>3 doses</td>
<td>3 doses</td>
<td>3 doses</td>
<td>3 doses</td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>1 dose</td>
<td>2 doses</td>
<td>1 dose</td>
<td>2 doses</td>
<td>1 dose</td>
</tr>
<tr>
<td>Haemophilus Influenza type b (Hib)</td>
<td>1 to 4 doses</td>
<td>Number of doses depends on the child’s age at the first dose; if you have questions, please consult with your physician.</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Pneumococcal Conjugate Vaccine (PCV)</td>
<td>1 to 4 doses</td>
<td>Number of doses depends on the child’s age at the first dose; if you have questions, please consult with your physician.</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Influenza</td>
<td>1 dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note to Parents:** The above schedule is the requirement for students who begin receiving their vaccines in infancy. There are different requirements for students who begin their vaccinations at a later age. If you have questions, please consult with your physician.

1. Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.


**For further information contact:**
New York State Department of Health, Bureau of Immunization, Room 649, Corning Tower ESP, Albany, NY 12237, (518) 473-4437.
New York City Department of Health and Mental Hygiene, Program Support Unit, Bureau of Immunization, 42-09 28th Street, 5th Floor, Long Island City, NY 11101, (347) 396-2433.
All students entering a New York City school for the first time must have a complete physical examination and all required immunizations. The comprehensive medical examination must be documented on a Child Adolescent Health Examination Form (CH205) and include the following:

- Weight
- Height
- Blood Pressure
- Body Mass Index
- Vision Screening
- Hearing Screening
- Dental Screening
- Medical History
- Developmental Assessment
- Nutritional Evaluation

The CH-205 examination must be performed on or after April 1st of the year of school entry. Examinations performed prior to April 1st of the entry year will not be accepted. Fillable CH-205 forms that include the student’s pre-populated vaccination histories are available through the New York City Immunization Registry (CIR). Students continuing on to Kindergarten from Pre-Kindergarten must submit a new CH-205.

**IMMUNIZATION REQUIREMENTS 2014–15**

The following immunization requirements are mandated by law for all students between the ages of two months and eighteen years. Children must be excluded from school if they do not meet these requirements. A child’s immunization history must include all of the following vaccines to be considered fully immunized. Their immunization record should be evaluated according to the grade they are attending this school year.

### PROVISIONAL REQUIREMENTS

New students may enter school provisionally with documentation of at least this initial series of immunizations. Once admitted provisionally, subsequent vaccines must be administered in accordance with the Advisory Committee for Immunization Practices (ACIP) ‘catch up’ schedule for the child to be considered ‘in process’ and remain in school (refer to [http://www.cdc.gov/vaccines/schedules/hcp/imz/catchup.html](http://www.cdc.gov/vaccines/schedules/hcp/imz/catchup.html) for schedule). Alternative schedules are not acceptable. Students must complete the entire series to comply with the law. Students who have not been immunized within the provisional period must be issued exclusion letters and excluded from school until they comply with the requirements.

<table>
<thead>
<tr>
<th>DAY CARE/PRE-KINDERGARTEN</th>
<th>NO. OF DOSES</th>
<th>KINDERGARTEN/GRDES 1–12</th>
<th>NO. OF DOSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP (diphtheria-tetanus-acellular pertussis) OR DTP (diphtheria-tetanus-pertussis)</td>
<td>1</td>
<td>DTaP, DTP, DT, Td (tetanus-diphtheria) OR Tdap (tetanus-diphtheria-acellular pertussis)</td>
<td>1</td>
</tr>
<tr>
<td>IPV (inactivated poliovirus) or OPV (oral poliovirus)</td>
<td>1</td>
<td>IPV or OPV</td>
<td>1</td>
</tr>
<tr>
<td>MMR (measles-mumps-rubella)</td>
<td>1</td>
<td>MMR</td>
<td>1</td>
</tr>
<tr>
<td>Hib (Haemophilus influenzae type b)</td>
<td>1</td>
<td>On or after the 1st birthday.</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>1</td>
<td>On or after the 1st birthday.</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal conjugate (PCV)</td>
<td>1</td>
<td>On or after the 1st birthday.</td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td>1</td>
<td>Depending on their influenza vaccination history, some children may need 2 doses of influenza vaccine.</td>
<td></td>
</tr>
<tr>
<td>Vaccine type as appropriate for age.</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>