Harrison Central School District
Harrison, New York

Dear Parents and Guardians of New Entrants:

Welcome to the Harrison Central School District. Attached are health forms to be completed and returned to the school nurse. The school district is required by New York State Public Health Law to have on file acceptable proof of immunization on each student upon entering school, and to identify and exclude from school any child that does not have evidence of the following:

- **A.** **Diphtheria:** 3 or more doses are required. A Pertussis booster, in the form of a Tdap vaccine is required for all students born on or after 1/1/94 and who are entering 6th grade.
- **B.** **Polio:** 3 or more doses are required.
- **C.** **Measles, Mumps, Rubella:** 2 doses of live Measles, 1 dose of live Mumps and 1 dose of live Rubella are required.
- **D.** **Hepatitis B:** 3 doses are required for all children born on or after 1/1/93.
- **E.** **Varicella (Chicken Pox):** 1 dose required for all children born on or after 1/1/98. Any new student born on or after 1/1/94 entering the district is required to have 1 dose.
- **F.** **Tuberculin Test:** A negative Tuberculin PPD test performed within 12 months of entry, where indicated by N.Y.S. and C.D.C. guidelines or signed waiver stating not at risk (see attached). BCG does not preclude a tuberculin test. Any positive reading warrants a chest x-ray.

The **PHYSICAL EXAMINATION FORM**, including Body Mass Index (BMI), is required for all new students. Examinations performed during the calendar year of entry are acceptable. If the exam form is not received by the school nurse, your child will automatically be scheduled for a health inspection by the school district's physician. Immunizations and diagnostic testing **are not** provided by the school district.

The **EMERGENCY INFORMATION CARD** is of great importance. Please complete and return promptly.

The **REFERENCE SHEET** lists health policies. Parents and students are urged to fully acquaint themselves with these policies.

The **DENTAL EXAM FORM** should be completed and returned before the **end** of the school year.

It is our goal to provide a healthy and safe environment for your child. Your attention to these forms is appreciated.

Sincerely,

School Nurse

1/30/08

HARRISON CENTRAL SCHOOL DISTRICT
Harrison, New York

Physical Exam Form

Name:	DOB:	Grade:

Height: _______________ Weight:_______________ Blood Pressure: _______________

Body Mass Index: __________ __________ . __________

Weight Status Category (BMI Percentile):

☐ Less than 5th ☐ 5th through 49th ☐ 50th through 84th

☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher

HISTORY AND PHYSICAL EXAMINATION, including nutrition, skin, scalp, hands, feet, eyes, ears, nose, teeth, tonsils and adenoids, lymphatics, heart, lungs, abdomen, genito-urinary, possible hernia, orthopedic and evaluation of neurological and emotional status, is normal, EXCEPT as indicated below:

Scoliosis: present:________ not present:________

Serious Illness or Operations:

Allergies:

Current Medication:

Diagnosis:

Recommendation:

Physical Activity: Full Physical Activity:_____ Restrictions as follows:_____

DTaP/DT/Td					
Tdap Boostrix					
Polio - IPV					

Live Measles Vaccine	#1	#2	Disease
Live Mumps Vaccine	#1	#2	Disease
Live Rubella Vaccine	#1	#2	Disease *(not acceptable without serology.)*
Varicella	#1	#2	
Hepatitis B Vaccine	#1	#2	#3
Hepatitis A	#1	#2	#3

TUBERCULIN TEST: A negative tuberculin PPD test performed within 12 months of entry, or signed waiver stating not at risk (see attached). BCG does not preclude a tuberculin test. Any positive reading warrants a chest x-ray.

Signature of Examining Physician:____

Address: ___________________________________ Telephone #: ___________________________

___________________________________ Date of exam: ___________________________

1/30/08

HARRISON CENTRAL SCHOOL DISTRICT
HARRISON, NEW YORK

STATEMENT OF IMMUNIZATIONS
The Amended New York State Public Health Law

Name of Child:	Birthdate:	
School:	Grade:	Room #:

Immunization records are not valid and cannot be accepted without the month, day and year for each dose given.

REQUIRED IMMUNIZATIONS

Dates of original and boosters - month, day, year:

DTaP/DT/Td					
Tdap / Boostrix					
POLIO IPV					
LIVE MEASLES 2 doses			(Measles Disease)		
LIVE MUMPS			(Mumps Disease)		

<table>
<tr><td>LIVE RUBELLA</td><td></td><td></td><td colspan="2">(Rubella Disease) Serology needed</td></tr>
<tr><td>VARICELLA</td><td>#1</td><td>#2</td><td></td><td></td></tr>
</table>

HEPATITIS B VACCINE	#1	#2	#3
HEPATITIS A VACCINE	#1	#2	#3

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PLEASE HAVE YOUR PHYSICIAN OR CLINIC FILL IN THIS FORM AND RETURN TO THE NURSE AT TIME OF REGISTRATION

(DATE)	Signature & stamp of Physician or Health Care Facility