

Immunization Regulations

Faith Elementary and Middle School

90 Saulsbury Road, Dover, DE 19904

TO: PARENTS / GUARDIAN / CAREGIVER

RE: **Compliance with Delaware Law and State Board of Education's Immunization Regulations**

Delaware Law and State Board of Education Regulations requires the following:

BIRTH CERTIFICATE - A birth certificate must be presented by all students entering school. If applicable, custody or guardianship papers are required.

PHYSICAL EXAMINATION - All pupils upon entrance to the Delaware school system shall have had a physical examination by a licensed medical physician, nurse practitioner or physician's assistant. The Physical Examination form can be given to the parent or guardian if requested.

New pupils have 14 school days to comply with the regulation before being excluded from school. A documented appointment with a licensed provider as stated above will defer exclusion.

IMMUNIZATIONS – All pupils must present documented proof and dates (mo/day/yr.) of the following:

- DTP** Four or more doses of DtaP, DTP or DT vaccine - a child receiving a fourth dose prior to the fourth birthday must have a fifth dose. A child who received the first dose of Td (adult) at or after age seven may meet this requirement with only three doses of Td (adult). A booster dose of Td (adult) is recommended for all students' five years after the last DtaP, DTP or DT dose was administered.
- POLIO** Three or more doses of IPV, OPV, or a combination of these vaccines with the following exception: A child who received a third dose prior to their fourth birthday must have a fourth dose.
- MEASLES** Two doses of measles vaccine - The first dose should be administered on or after the age of 12 months. The second dose should be administered after the fourth birthday and may be a combined measles, mumps, and rubella (MMR) vaccine.
- MUMPS** One dose of mumps vaccine should be administered after the age of 12 months.
- RUBELLA** One dose of rubella vaccine should be administered after the age of 12 months.
- HEPATITIS B** Three doses of Hepatitis B vaccine beginning in the 1999-2000 school year with Kindergarten and grade seven. (By adding a grade at each of the levels, by the year 2004-2005 all students will be required to have the vaccine). Two doses of CDC approved vaccine for children ages 11-15 may be used.
- VARICELLA** Vaccine or documentation of disease history.
- TUBERCULOSIS** AD new students entering school shall show proof of a Mantoux tuberculin skin Test results.
- SKIN TEST** within the past 12 months or follow the recommendations of the American Academy of Pediatrics (AAP). Health Care Providers must send documentation of the decisions. Multi-puncture skin test will not be accepted.
- LEAD SCREENING** For every child born or after March 1, 1995, and who has reached the age of 12 months, child care facilities, public and private nursery schools, preschools and kindergartens shall require screening for lead poisoning for admission or continued enrollment.

Written documentation from a doctor must be presented if a child cannot receive any of the above immunizations due to medical reasons or a notarized affidavit of religious belief must be presented if you are seeking a religious exemption.

Please contact the School Administrator with any questions concerning these requirements.

YOUR CHILD WILL ATTEND SCHOOL ONLY IF YOU PROVIDE THE SCHOOL WITH ALL OF THE ABOVE REQUIREMENTS.

Last Name	First and Middle Name	M	F	Date of Birth	*
-----------	-----------------------	---	---	---------------	---

SCHOOL HEALTH RECORD – STATE OF DELAWARE

Parent/Guardian Name: _____

Medical Alert	
<i>(Chronic illness, Injury, Surgery, with Date; example: 4/98 Asthma)</i>	

School Student is Attending													
<i>(Record School Number)</i>													
Pre-KN	KN	1	2	3	4	5	6	7	8	9	10	11	12

Immunizations							
<i>(May attach State Form)</i>							
Exempt	Type	1	2	3	4	5	6
	DTP/DtaP						
	OPV/IPV						
	Hep B						
	Measles						
	Mumps						
	Rubella						
	HIB						
	Varicella						
	Other						

Testing									
Date	Test	Type (circle one)	Results	Initials	Date	Test	Type (circle one)	Results	Initials
	TB	PPD/Risk Assess				Lead	Blood		

Physical Examinations					
<i>(Documentation in Student's File)</i>					
Date	Significant Findings		Date	Significant Findings	

Long-term Medications					
Name	Start	Stop	Name	Start	Stop

School Nurse Name and Initials	

Student Name: (Last) _____ (First) _____

Screening Results

Vision Screening <small>(Record Actual Acuity, ex: 20/20, 10/10, etc.)</small>								Color Test Date: _____ <u>Pass</u> <u>Fail</u> Depth Perception Date: _____ <u>Pass</u> <u>Fail</u>					
Grade													
Date													
Device													
Acuity: Far R													
L													
Both													
Near R													
L													
Both													
Glasses/Contacts													
Muscle Balance													
Initials													

Hearing Screening <small>(P = Pass; F = Fail)</small>													
Grade													
Date													
Decibels													
R 1000													
2000													
4000													
L 1000													
2000													
4000													
Aid													
Initials													

Postural Screening					
Grade					
Phase I Date					
Results					
Phase II Date					
Initials					

Other Information <small>(Ex: Comments, Conferences, etc)</small>

Referral Information <small>(Follow Up for Screenings Only)</small>					
Issue/Concern	Date Sent	Follow-up Summary	Issue/Concern	Date Sent	Follow-up Summary

