THE HOTCHKISS SCHOOL DUE BY JULY 15th
WIELER HEALTH CENTER
REQUIRED STUDENT HEALTH EXAM
TO BE COMPLETED BY HEALTH CARE PROVIDER

NAME: _____DATE OF BIRTH: _____

I. PHYSICAL EXAMINATION BY HEALTH CARE PROVIDER REQUIRED:

BP:_____ P:_____ Height:_____ Weight:_____
Eyes:_____ Lungs:_____
Ears:_____ Abdomen:_____
Nose and Throat:_____ Genitalia:_____
Teeth:_____ Extremities:_____
Skin:_____
Lymph Nodes:_____ **LABS**
Heart:_____ Urinalysis:_____
Murmurs:_____ Hemoglobin or Hematocrit:_____
Enlargement:_____

II. Allergies to medications:_____
Other allergies – please describe:_____
Epi-pen or Auvi-Q required ❑ YES ❑ NO Explain:_____

III. Please list any medications and dosages:_____
_____
_____

The Permission to Administer Medications form must be completed for all prescription medications. *For compliance with safety standards,* ***all medication that is required to be stored in the Health Center, including, but not limited to controlled narcotics, stimulant medications, and psychotropic medications, must be in pre-packaged individual dose packets*** *as Health Center staff are not permitted to repackage medication. We have partnered with Petricone's Pharmacy for the delivery of medication to campus in the required packaging. We encourage you to establish an account with them by calling 860-489-5511.*

IV. **Please provide details** of (1) psychiatric care or treatment, (2) fractures, (3) surgeries, (4) concussions, (5) any other problems beyond routine childhood illnesses.
_____
_____
_____

V. Is this student capable of physical activity and participation in a competitive athletic program? ❑ YES ❑ NO
Please advise if there are any restrictions, conditions, or injuries._____
_____

Name of Examiner:_____

Signature of Examiner:_____Date:_____

Address:_____Telephone:_____

e-mail:_____Fax:_____

The Hotchkiss School Immunization Record

Name of Student:_____ Date of Birth:_____

The following immunizations are **REQUIRED FOR STUDENTS TO ATTEND CLASSES by The State of Connecticut and/or The Hotchkiss School**. This form must be completed by a Physician, PA or APRN.

DATE EACH DOSE IS GIVEN (month/day/year)

REQUIRED VACCINES	1st Mo/Day/Yr	2nd Mo/Day/Yr	3rd Mo/Day/Yr	4th Mo/Day/Yr	5th Mo/Day/Yr
Polio – At least 3 doses required. The last dose must be on or after the 4th birthday.					
DTaP - At least 3 doses required, one of which should be Tdap.					
Tdap – Required					
***MMR –** 2 doses required. 1st dose must be on or after the 1st birthday and the 2nd dose must be at least 28 days after the 1st dose. *If a student has a history of measles, mumps, or rubella it must be confirmed in writing by specific blood testing.*					
***Varicella –** 2 doses required or verification of disease. 1st dose must be on or after the 1st birthday. Minimum interval between doses: 3 months if person was younger than age 13 years, 4 weeks if person was age 13 years or older.			Verification of Chicken Pox Disease by MD, PA, APRN, or lab confirmation:		
Meningococcal – 1st dose required at age 11-12 years and a 2nd dose at age 16 years. If the 1st dose is given at 13-15 years, the 2nd dose should be at 16-18 years with at least 8 weeks between doses. If the 1st dose is given after the 16th birthday, a second dose is not required.					
Hepatitis B – 3 doses required. At least 4 weeks between doses 1 and 2; 8 weeks between doses 2 and 3; 16 weeks between doses 1 and 3. Dose 3 should not be given before 24 weeks of age.					
Hepatitis A – 2 doses required for those born on or after January 1, 2007. 1st dose must be on or after the 1st birthday and the second dose must be at least 6 months after the 1st.					
COVID-19 – please note specific vaccine received: _____					

*If MMR and Varicella are not administered on the same day, they must be separated by at least 28 days.

Additional Vaccines	DATES GIVEN
Hemophilus (Hib)	
HPV (highly recommended)	
Meningitis B (recommended)	
Typhoid	
Yellow Fever	
OTHER	

Signature of Examiner:_____Date:_____