Beth Tfiloh Dahan Community School

June 2011

Dear Parents,

Please carefully read the enclosed health information provided in this packet and follow the directions for your specific grade requirements. **ALL FORMS MUST BE RETURNED TO SCHOOL BY AUGUST 5, 2011.**

The Baltimore County Health Department requires that all immunizations are up to date prior to the start of the school year. Children will be sent home if all immunizations are not complete.

Enclosed you will find the following (click on a form's link to view and print it):

- Annual Beth Tfiloh Health Questionnaire
- Maryland Health Assessment, Immunization Certificate and Dental Health Record
- Physician's Instructions for Giving Medication in School (if needed)
- Athletic Permit/Medical Release & Physical Examination Form (required for Middle School and High School students participating in interscholastic team sports)

The Annual Beth Tfiloh Health Questionnaire **must** be filled out **every year for ALL Beth Tfiloh students by their parents/guardians.**

The Maryland Health Assessment, Immunization Certificate and Dental Health Record is required for all NEW students (i.e. not enrolled at BT last year) and all CONTINUING students entering the following grades:

- All PreSchool & Gan Aleph students
- Kindergarten
- Grade 5
- Grade 9

The Maryland Health Assessment must be completed by both parent/guardian and your health care provider. Parent/guardian completes **Part I** and your heath care provider must complete **Part II**.

Thank you for your cooperation. We look forward to a healthy and productive school year.

Sincerely,

Zipora Schorr
Director of Education

PreSchool through High School Learning together. For life.
3300 Old Court Road / Baltimore, Maryland 21208 / 410-486-1905 / mail@btfiloh.org / bethtfiloh.com
Beth Tfiloh Dahan Community School is the grateful recipient of THE ASSOCIATED/Weinberg Day School Initiative

Beth Tfiloh Dahan Community School

## HEALTH INFORMATION

Attached is the Beth Tfiloh Health Questionnaire requesting information concerning your child's medical, social and emotional history. This information, though sensitive, will enable us to understand and better care for you child throughout the school day. We encourage you to share as much information as possible, including all medications taken at home prior to school. **ALL OF THE INFORMATION ON THESE FORMS WILL BE KEPT IN STRICT CONFIDENCE.**

Guidelines used for giving proper health care to your child are based on policies of the Baltimore County Health Department and are as follows:

1 A child with a temperature of 100.0 degrees or above is not permitted to be in school. The child must have a normal temperature for **24 hours** (**without Tylenol or Motrin/Advil**) before returning to school.

2 Any child with a communicable disease is not permitted in school. However, **head lice** is addressed individually by the school nurse. Once it is determined by the nurse that the family is treating their case thoroughly, the child will be permitted to attend school, with their hair covered and/or pulled back. The nurse will monitor the student until they are completely free of nits. View Head Lice Policy

3 The following non-prescription medications will be available in an effort to relieve minor discomforts which impede student learning and prevent full participation in classroom activities: Acetaminophen (Tylenol), Ibuprofen (Motrin or Advil), anti-itch ointment, hydrocortisone, bacitracin, Tums, sunscreen and Benadryl for allergic reactions only. **A CONSENT FORM MUST BE COMPLETED AND SIGNED BEFORE ANY MEDICATIONS WILL BE ADMINISTERED!!** (See Page 1 of the Beth Tfiloh 2011-2012 Annual Health Questionnaire.)

4 All medications to be administered at school, **PRESCRIPTION** and **OVER-THE-COUNTER,** MUST be **accompanied by a written order** from your health care provider. A parent must bring the medication to school in the **original container.** The order and medication must include name, date, dosage, instructions and doctor's name. If your child starts a new medication, or the current dosage is adjusted, please notify the school immediately. NO STUDENT WILL BE ALLOWED TO CARRY AND SELF-ADMINISTER MEDICATION. Please notify the nurse of special circumstances authorized by a physician. View School Medication Administration Authorization Form.

5 Immunizations must be current prior to attending school. Note: All kindergarteners must have had 5 DPT, 4 polio, 2 MMR, and 3 hepatitis B vaccines. Documentation of varicella (chicken pox) vaccination or history of the disease must be included. **Students new** to the school or those **entering Preschool, Gan Aleph, Kindergarten, 5th grade and 9th grade** will need a Maryland Health Assessment form, Immunization certificate and physical exam completed by their health care provider. Be sure that both **Part I (Parents)** and **Part II (health care provider)** are complete. **ALL students** attending Beth Tfiloh Dahan Community School must complete the Beth Tfiloh Health Questionnaire every year. **BALTIMORE COUNTY LAW MANDATES THAT ALL FORMS MUST BE TURNED IN ON OR BEFORE THE FIRST DAY OF SCHOOL.** View Baltimore County Immunization Requirements.

*- Continued-*

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The following Health and Wellness policies have been posted to our website at www.bethtfiloh.com/health. Please refer to them for specific guidelines as needed:

- Head Lice Policy
- Concussion Policy and Procedures
- Revised Car Seat Recommendations for Children
- Nutrition Nuggets

If there is any information about your child that you would like to discuss with our health team, please feel free to call or send a note with your completed forms.

Thank you for your time; we appreciate working with you so that we may provide the best possible care for your child.

THE BETH TFILOH HEALTH AND WELLNESS TEAM

**Middle & High School**
410-484-5073
Judy Elbaum RN
Nancy Levine RN

**PreSchool & Lower School**
410-413-2512
Wendy Quartner RN
Stacy Schwartz RN CPNP

Debbie Disney LCSW-C 410-413-2326

MS Fax 410-415-5280
HS Fax 410-653-7224

PS Fax 410-415-5280
LS Fax 410-526-6753

REQUIRED FOR ALL STUDENTS

Beth Tfiloh Dahan Community School

## 2011-2012 ANNUAL HEALTH QUESTIONNAIRE

**STUDENT'S NAME:** ______________________ **ENTERING GRADE:** ____________

**ALLERGIES/ALL TYPES ...... Y N**

- Allergic to: ______________________
- Expected reaction ______________________
- Treatment ______________________

**ASTHMA ................................ Y N**

- Inhaler/Nebulizer used in school ______________________

*Reminder: All medications that your child may need at school must be provided and accompanied by a doctor's order **except** for the medications listed below:

**CONSENT TO GIVING NON-PRESCRIPTION MEDICATIONS IN SCHOOL**

**Please check any medications you wish to be made available to your child:**

- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofen (Advil, Motrin)
- ☐ Tums
- ☐ Benadryl (For allergic reactions only)
- ☐ Hydrocortisone 1%
- ☐ Anti-itch gel
- ☐ Antibiotic Ointment
- ☐ Sunscreen

☐ **I do not want any medications given to my child in school.**

**Signature of parent or Guardian** ______________________ **Date** ____________

**Home Phone** ____________ **Work** ____________ **Cell** ____________

Doctor's Name ______________________ Phone ____________

Dentist's Name ______________________ Phone ____________

Medication or treatment taken at home ( Dosage, time, purpose-for example: Ritalin 10 mg 7 AM ADHD)

______________________

______________________

Medication or treatment that may be needed by your child at school ______________________

______________________

Date of last Tetanus ______________________

Any vaccines received within the last year ______________________

*(continued on next page)*

**MEDICAL HISTORY**

**Does your child have a history of the following? Please circle and explain.**

- Attention disorder/ADHD................................................**Y N** ____________________
- Bladder/Bowel concerns................................................**Y N** ____________________
- Dental concerns................................................**Y N** ____________________
- Fainting................................................**Y N** ____________________
- Frequent nosebleeds................................................**Y N** ____________________
- Frequent or severe headaches................................................**Y N** Medication used: ____________________

  If yes, how frequent length/duration ____________________
- Frequent stomach aches................................................**Y N** ____________________
- Head Injury or concussion................................................**Y N** ____________________
- Heart condition................................................**Y N** ____________________
- Hearing problems................................................**Y N** ____________________
- Learning differences................................................**Y N** ____________________
- Menstrual cramps................................................**Y N** ____________________
- Seizures or epilepsy................................................**Y N** ____________________
- Serious injury, illness, or hospitalization................................................**Y N** ____________________
- Vision concerns................................................**Y N** ____________________
- Weight fluctuations, Eating disorder, Special diet................................................**Y N** ____________________
- Other health concerns................................................**Y N** ____________________

**SOCIAL/EMOTIONAL DEVELOPMENT:**

- Aggressive behavior/Anger management................................................**Y N** ____________________
- Anxiety/Nervous/Fears/Phobias................................................**Y N** ____________________
- Death/Illness of close family member................................................**Y N** ____________________
- Difficulty making/keeping friends................................................**Y N** ____________________
- Easily frustrated................................................**Y N** ____________________
- Frequent body complaints................................................**Y N** ____________________
- Parental separation/Divorce................................................**Y N** ____________________
- Recent move or other significant change................................................**Y N** ____________________
- Self-injurious behavior................................................**Y N** ____________________
- Shy or withdrawn................................................**Y N** ____________________
- Sleep difficulty................................................**Y N** ____________________
- Speaks unclearly/Stutters................................................**Y N** ____________________
- Social skills................................................**Y N** ____________________
- Is your child receiving mental health support?........**Y N** With whom? ____________________
- Does your child receive speech, occupational, or physical therapy? **Y N** With whom? ____________________
- If not, do you feel your child would benefit from the above? **Y N** ____________________

Is there any additional information regarding your child that you would like to share with the school?

____________________________________________________________

____________________________________________________________

Beth Tfiloh Dahan Community School

**PHYSICIAN'S INSTRUCTIONS FOR GIVING MEDICATION IN SCHOOL**

August, 2011

Dear Parent,

We attempt to discourage administration of medication in the schools. However, if your physician decides it is necessary for your child to receive a medication during the school day, his/her **WRITTEN** approval and specific directions must be provided to the school. It is recommended the first doses of medication be administered at home.

Send the medication to the school in the original or a duplicate box or bottle with the current prescription label on the container. Upon request, pharmacists have labeled containers to be used.

Please take the form on the Zc``ck]b[ ˙dU[ Yto your physician and have the instructions recorded regarding the administration of your child's medication.

If you have any questions regarding this procedure, please contact your school office to be connected to the Health Suite.


3300 Old Court Road / Baltimore, Maryland 21208 / 410-486-1905 / mail@btfiloh.org / bethtfiloh.com
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# MARYLAND STATE
# SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

**This order is valid only for school year (current) __________________ including the summer session.**

**School:** ______________________________________________________________________

**This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.**

* Prescription medication must be in a container labeled by the pharmacist or prescriber.
* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school.
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

## Prescriber's Authorization

Name of Student: ______________________ Date of Birth: ____________________ Grade: _______

Condition for which medication is being administered: ________________________________

Medication Name: ______________________ Dose: ______________ Route: ______________

Time/frequency of administration: ______________________ If PRN, frequency: ______________

If PRN, for what symptoms: ____________________________________________

Relevant side effects: ☐ None expected ☐ Specify: ______________________________

Medication shall be administered from: ______________________ to ______________________
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: ______________________________
(Type or print)

Telephone: ______________ FAX: ______________

Address: ______________________________

______________________________

Prescriber's Signature: ______________________ Date: __________
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): ______________ for the above medication on (Date): __________

## PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: ______________________________ Date: ______________

Home Phone #: ______________ Cell Phone #: ______________ Work Phone #: ______________

## SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: ______________________
Signature Date

School RN approval for self carry/self administration of emergency medication: ______________________
Signature Date

Order reviewed by the school RN: ______________________________________________
Signature Date

2004

REQUIRED for all NEW students and CONTINUING students in PreSchool, Kindergarten, Grade 5, and Grade 9 Return to Top

## PART I - HEALTH ASSESSMENT

### To be completed by parent or guardian

| Student's Name (Last, First, Middle) | Birthdate (Mo. Day Yr.) | Sex (M/F) | Name of School | Grade |
| --- | --- | --- | --- | --- |
| | | | | |

Address (Number, Street, City, State, Zip) Phone No.

Parent/Guardian Names

Where do you usually take your child for routine medical care? Phone No.

Name: Address:

When was the last time your child had a physical exam? Month Year

Where do you usually take your child for dental care? Phone No.

Name: Address:

ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge has your child any problem with the following? Please check

| | Yes | No | Comments |
| --- | --- | --- | --- |
| Allergies (Food, Insects, Drugs, Latex) | | | |
| Allergies (Seasonal) | | | |
| Asthma or Breathing Problems | | | |
| Behavior or Emotional Problems | | | |
| Birth Defects | | | |
| Bleeding Problems | | | |
| Cerebral Palsy | | | |
| Dental | | | |
| Diabetes | | | |
| Ear Problems or Deafness | | | |
| Eye or Vision Problems | | | |
| Head Injury | | | |
| Heart Problems | | | |
| Hospitalization (When, Where) | | | |
| Lead Poisoning/Exposure | | | |
| Learning problems/disabilities | | | |
| Limits on Physical Activity | | | |
| Meningitis | | | |
| Prematurity | | | |
| Problem with Bladder | | | |
| Problem with Bowels | | | |
| Problem with Coughing | | | |
| Seizures | | | |
| Serious Allergic Reactions | | | |
| Sickle Cell Disease | | | |
| Speech Problems | | | |
| Surgery | | | |
| Other | | | |

Does your child take any medication?

No Yes Name(s) of Medications: ________________________________________________

Is your child on any special treatments? (nebulizer, epi-pen, etc.)

No Yes Treatment ___________________________________________________________

Does your child require any special procedures? (catheterization, etc.)

No Yes

Parent/Guardian Signature ________________________________________ Date:____________________

REQUIRED for all NEW students and CONTINUING students in PreSchool, Kindergarten, Grade 5, and Grade 9

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# PART II - SCHOOL HEALTH ASSESSMENT

To be completed **ONLY** by Physician/Nurse Practitioner

| Student's Name (Last, First, Middle) | Birthdate (Mo. Day Yr.) | Sex (M/F) | Name of School | Grade |
|---|---|---|---|---|
| | | | | |

1. Does the child have a diagnosed medical condition?
   No Yes ______________________________

   ______________________________

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".
   No Yes______________________________

   ______________________________

3. Are there any abnormal findings on evaluation for concern?

Evaluation Findings/CONCERNS

| Physical Exam | WNL | ABNL | Area of Concern | Health Area of Concern | YES | NO |
|---|---|---|---|---|---|---|
| Head | | | | Attention Deficit/Hyperactivity | | |
| Eyes | | | | Behavior/Adjustment | | |
| ENT | | | | Development | | |
| Dental | | | | Hearing | | |
| Respiratory | | | | Immunodeficiency | | |
| Cardiac | | | | Lead Exposure/Elevated Lead | | |
| GI | | | | Learning Disabilities/Problems | | |
| GU | | | | Mobility | | |
| Musculoskeletal/orthopedic | | | | Nutrition | | |
| Neurological | | | | Physical Illness/Impairment | | |
| Skin | | | | Psychosocial | | |
| Endocrine | | | | Speech/Language | | |
| Psychosocial | | | | Vision | | |
| | | | | Other | | |

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider <u>**or**</u> a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis. ______________________________
   No Yes ~
   **(A medication administration form must be completed for medication administration in school).**

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.
   No Yes ______________________________

| 7. **Screenings** | **Results** | **Date Taken** |
|---|---|---|
| Tuberculin Test | | |
| Blood Pressure | | |
| Height | | |
| Weight | | |
| BMI %tile | | |
| Lead Test | Optional | |

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**PART II - SCHOOL HEALTH ASSESSMENT - continued**

To be completed **ONLY** by Physician/Nurse Practitioner

(Child's Name) ______________________________________________ has had a complete physical examination and has

9 no evident problem that may affect learning or full school participation problems noted above

_______________________________________________________________________________

Additional Comments:

| Physician/Nurse Practitioner (Type or Print) | Phone No. | Physician/Nurse Practitioner Signature | Date |
|---|---|---|---|
| | | | |

REQUIRED for all NEW students and CONTINUING students in PreSchool, Kindergarten, Grade 5, and Grade 9

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# MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME________________________________________________
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_________/_________/_________

COUNTY ______________________ SCHOOL______________________ GRADE_______

PARENT OR GUARDIAN NAME ______________________ PHONE NO. ______________________

ADDRESS ______________________ CITY ______________________ ZIP_________

## RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

| Dose # | DTP-DTaP-DT Mo/Day/Yr | Polio Mo/Day/Yr | Hib Mo/Day/Yr | Hep B Mo/Day/Yr | PCV Mo/Day/Yr | Rotavirus Mo/Day/Yr | MCV Mo/Day/Yr | HPV Mo/Day/Yr |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |

| Dose # | Hep A Mo/Day/Yr | MMR Mo/Day/Yr | Varicella Mo/Day/Yr | History of Varicella Disease Mo/Yr |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |

| Td Mo/Day/Yr | Tdap Mo/Day/Yr | FLU Mo/Day/Yr | Other Mo/Day/Yr |
|---|---|---|---|
| ______ | ______ | ______ | ______ |
| ______ | ______ | ______ | ______ |
| ______ | | | |

To the best of my knowledge, the vaccines listed above were administered as indicated.

1. ______________________________________________
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. ______________________________________________
Signature Title Date

3. ______________________________________________
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

Clinic / Office Name
Office Address/ Phone Number

**LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)**

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: ______________________________________________ Date: ______________________
Parent or Guardian

---

**COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.**

**MEDICAL CONTRAINDICATION:**

The above child has a valid medical contraindication to being immunized at this time.

This is a ☐ permanent condition ☐ temporary condition until _______/________/________

Check appropriate box, indicate vaccine(s) and reasons: ______________________________________________

Signed: ______________________________________________ Date ______________________
Medical Provider / LHD Official

**RELIGIOUS OBJECTION:**

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: ______________________________________________ Date: ______________________

# How To Use This Form

The medical provider that gave the vaccinations may record the dates directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, per each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

**Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.**

**Notes:**

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

# Immunization Requirements

The following excerpt from the DHMH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; and (h) Varicella."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and DHMH COMAR 10.06.04.03 are available at www.EDCP.org (Immunization).

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the "**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**" guideline chart are available at www.EDCP.org (Immunization).

# Vaccine Requirements For Children
## Enrolled in Preschool Programs and in Schools — Per DHMH COMAR 10.06.04.03
## Maryland School Year 2011 - 2012 (Valid 9/1/11 - 8/31/12)

**Required cumulative number of doses for each vaccine for PRESCHOOL aged children enrolled in educational programs**

| Vaccine / Current Age of Child | DTaP/DTP/ DT | Polio[2] | Hib[3] | Measles[2,4] | Mumps[2,4] | Rubella[2,4] | Varicella[2,4,5] (Chickenpox) | Hepatitis B | PCV[3] (Prevnar™) |
|---|---|---|---|---|---|---|---|---|---|
| **Less than 2 months** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| **2 - 3 months** | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 1 |
| **4 - 5 months** | 2 | 2 | 2 | 0 | 0 | 0 | 0 | 2 | 2 |
| **6 - 11 months** | 3 | 3 | 2 | 0 | 0 | 0 | 0 | 3 | 2 |
| **12 - 14 months** | 3 | 3 | At least 1 dose given after 12 months of age | 1 | 1 | 1 | 1 | 3 | 2 |
| **15 - 23 months** | 4 | 3 | At least 1 dose given after 12 months of age | 1 | 1 | 1 | 1 | 3 | 2 |
| **24—59 months** | 4 | 3 | At least 1 dose given after 12 months of age | 1 | 1 | 1 | 1 | 3 | 1 |
| **60 - 71 months** | 4 | 3 | 0 | 2 | 2 | 2 | 1 | 3 | 0 |

**Required cumulative number of doses for each vaccine for children enrolled in KINDERGARTEN - 12th grade**

| Grade Level: Grade | (Ungraded) | DTaP/DTP/ Tdap/DT/Td[1] | Polio[2,7] | Measles[2,4] | Mumps[2,4] | Rubella[2,4] | Varicella[2,4] (Chickenpox) | Hepatitis B[8] |
|---|---|---|---|---|---|---|---|---|
| **Kindergarten** | (5 yrs) | 4 | 3 | 2 | 1 | 1 | 1 | 3 |
| **Grades 1 - 12** | (6 - 18+ yrs) | 4 or 3[6] | 3 | 2 | 1 | 1 | 1 or 2[5] | 3 |

* See footnotes on back

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# Vaccine Requirements For Children Enrolled in Preschool Programs and in Schools Maryland School Year 2011 - 2012 (Valid 9/1/11 - 8/31/12)

## FOOTNOTES

1. If DT vaccine is given in place of DTP or DTaP, a physician documented medical contraindication is required.

2. Proof of immunity by positive blood test is acceptable in lieu of vaccine history for hepatitis B, polio and measles, mumps, rubella and varicella.

3. Hib and PCV(Prevnar™) are not required for children older than 59 months (5 years) of age.

4. All doses of measles, mumps, rubella and varicella vaccines should be given on or after the first birthday. However, upon record review for students in preschool through 12th grade, a preschool or school may count as valid vaccine doses administered less than or equal to four (4) days before first birthday.

5. One dose of varicella (chickenpox) is required for a student younger than 13 years old. Two doses of varicella vaccine are required for a previously unvaccinated student 13 years of age or older. Medical diagnosis of varicella disease is acceptable in lieu of vaccination. Medical diagnosis is documented history of disease provided by a physician or health care provider. Documentation must include month and year. In the absence of documentation a medical provider or local health department may verify immunity via blood test, **but revaccination may be more expedient.**

6. Four (4) doses of DTP/DTaP are required for children less than 7 years old. Three (3) doses of tetanus and diphtheria containing vaccines (DTP, DTaP, Tdap, DT or Td) are required for children 7 years of age and older.

7. Polio vaccine is not required for persons 18 years of age and older.

8. Two doses of Hepatitis B vaccine is acceptable only if the student was vaccinated with the Merck & Co. brand vaccine **Recombivax™ HB Adult Formulation**. Recombivax™ HB Adult Formulation vaccine is licensed for use in adolescents 11 - 15 years of age as a two-dose series.

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**REQUIRED for all NEW students and CONTINUING students in PreSchool, Kindergarten, Grade 5, and Grade 9**

# BALTIMORE COUNTY DEPARTMENT OF HEALTH

Division of School Health

## SCHOOL DENTAL HEALTH RECORD

Please take this form to your family dentist when your child has his next dental appointment.
Have your dentist complete the form and have your child return the form to the school nurse.

Name of Student ______________________________ Date ______________

Name of School ______________________________ Age ______________

School Nurse ______________________________ Grade ______________

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

REPORT OF DENTAL EXAMINATION:

☐ No dental treatment is necessary

☐ All necessary dental treatment has been completed

☐ Treatment is in progress

FURTHER RECOMMENDATIONS ______________________________________________

________________________________________________________________

________________________________________________________________

Dentist's Signature ______________________________ Date ______________

Dentist's Name ______________________________ Phone ______________

Address ________________________________________________________

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# Beth Tfiloh Community School
# Athletic Permit / Medical Release Form

**(Please return this form to the Athletic Department)**

**Participants name: ________________________________ Grade: _____ Date of Birth: ________**

**Address:_______________________________________________________________________**

**Home Phone:____________________________ School:________________________________**

**In an emergency notify:_______________________________ Phone #:____________________**

**Family Doctor:______________________________________ Phone #:____________________**

**Date of last exam:__________________________**

**Any limitations or known allergies? _________________________________________________**

**We give our consent for Beth Tfiloh staff to use their own judgement in securing medical aid and ambulance service in case the parents cannot be reached: ______yes ______no**

**Please check a space: ______ Student is covered by schools insurance**

**______ Blue Cross/ Blue Shield (policy #) ___________________**

**______ Other commercial insurance (policy # and company)________________**

**It is understood that time after school will be required for practice and competition. The school will provide proper and reasonable supervision at practices and games. Beyond this point of proper supervision, the school cannot assume responsibility for injuries. Additionally, a student is financially responsible for replacement cost of athletic equipment and uniforms which are not returned within ten days after the close of a given season.**

**I have read and completed the above form and I hereby give my son/daughter permission to participate.**

**Date: _______________ Signed:___________________________________**

REQUIRED for al MS & HS students participating in interscholastic team sports

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# ATHLETIC DEPARTMENT

**(Please return this form to the Athletic Department)**

## PHYSICAL EXAMINATION FORM

**I hereby certify that I have examined**

______________________________________________________________________

**FIRST** **MIDDLE** **LAST**

**GRADE:__** __________

**and have found that he/she is medically capable of participating in a full range of Interscholastic Sports with NO LIMITATIONS.**

**Name of Physician:** ____________________________________________

**Telephone Number:** ____________________________________________

**Date of Examination:** ____________________________________________

**Physician's Signature:** ____________________________________________

**COMMENTS:** ____________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________