

Litchfield High School

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Theresa Simaitis, R.N.
School nurse

Moving to Litchfield - School Year 2017-2018

Dear Parents,

Welcome to Litchfield High School. It is with pleasure that I would like to review with you the State of Connecticut regulations concerning admittance to a public school.

As the School Nurse at LHS, the health and safety of your child is my major concern. With his in mind, let me review the qualifications of admittance to LHS.

- Prior to school entry, a written copy of your child's immunizations is required. These immunizations must include the day, month, and year of the immunization.
- The following two immunizations, DPT (Diphtheria/Pertussis/Tetanus) and Polio, must have been given on or after the 4th birthday. If either was last given prior to the 4th birthday, an additional immunization must be given prior to the first day of school.
- Students entering 7th and 8th grade, must show proof of Meningococcal vaccine and a Tdap (Tetanus/Diphtheria/Pertussis) booster vaccine prior to entry.
- All students are required to show proof of immunity to varicella (chickenpox) for entry. Proof of immunity includes any of the following: 1) documentation of immunization 2) serological evidence of past infection or 3) a statement signed and dated by a physician stating that the child has already had chickenpox based on family and/or medical history. Students entering 7th and 8th grade must show proof of a 2nd varicella booster vaccine
- All students must show receipt of all 3 doses of Hepatitis B vaccination
- Please see attached State of Connecticut requirements for newly enrolled students
- If you are entering from another state or country, a complete physical on the blue State of Connecticut physical form (available from LHS) is required within the last year. This must be done prior to the first day of school.
- If you are transferring from another school in Connecticut, a complete physical on the blue State of Connecticut physical form is necessary for 6th and 10th grade students only.
- Any child determined to be at high risk for tuberculosis and those from high risk countries entering school in Connecticut for the first time should receive a tuberculosis skin test prior to school entry.

Again, welcome to LHS. Please call (567-7533) or stop in and let me greet you and your student and answer any questions you may have.

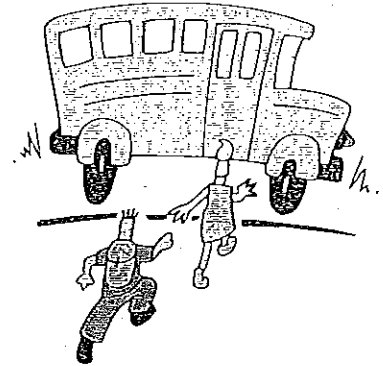
Sincerely,
Theresa Simaitis, R.N.



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

IMMUNIZATION REQUIREMENTS FOR ENROLLED STUDENTS IN CONNECTICUT SCHOOLS 2017-2018 SCHOOL YEAR



PRESCHOOL

DTaP:	4 doses (by 18 months for programs with children 18 months of age)
Polio:	3 doses (by 18 months for programs with children 18 months of age)
MMR:	1 dose on or after 1 st birthday
Hep B:	3 doses, last one on or after 24 weeks of age
Varicella:	1 dose on or after 1 st birthday or verification of disease
Hib:	1 dose on or after 1 st birthday
Pneumococcal:	1 dose on or after 1 st birthday
Influenza:	1 dose administered each year between August 1 st -December 31 st (2 doses separated by at least 28 days required for those receiving flu for the first time)
Hepatitis A:	2 doses given six calendar months apart, 1 st dose on or after 1 st birthday

KINDERGARTEN

DTaP:	At least 4 doses. The last dose must be given on or after 4 th birthday
Polio:	At least 3 doses. The last dose must be given on or after 4 th birthday
MMR:	2 doses separated by at least 28 days, 1 st dose on or after 1 st birthday
Hep B:	3 doses, last dose on or after 24 weeks of age
Varicella:	2 doses separated by at least 3 months-1 st dose on or after 1 st birthday; or verification of disease
Hib:	1 dose on or after 1 st birthday for children less than 5 years old
Pneumococcal:	1 dose on or after 1 st birthday for children less than 5 years old
Hepatitis A:	2 doses given six calendar months apart, 1 st dose on or after 1 st birthday

GRADES 1-5

DTaP/Td:	At least 4 doses. The last dose must be given on or after 4 th birthday. Students who start the series at age 7 or older only need a total of 3 doses.
Polio:	At least 3 doses. The last dose must be given on or after 4 th birthday
MMR:	2 doses separated by at least 28 days, 1 st dose on or after 1 st birthday
Hep B:	3 doses, last dose on or after 24 weeks of age
Varicella:	2 doses separated by at least 3 months-1 st dose on or after 1 st birthday; or verification of disease
Hepatitis A:	2 doses given six calendar months apart, 1 st dose on or after 1 st birthday

GRADE 6

DTaP/Td:	At least 4 doses. The last dose must be given on or after 4 th birthday. Students who start the series at age 7 or older only need a total of 3 doses.
Polio:	At least 3 doses. The last dose must be given on or after 4 th birthday
MMR:	2 doses separated by at least 28 days, 1 st dose on or after 1 st birthday
Hep B:	3 doses, last dose on or after 24 weeks
Varicella:	2 doses separated by at least 3 months-1 st dose on or after 1 st birthday; or verification of disease

GRADES 7-12

Tdap/Td:	1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap
Polio:	At least 3 doses. The last dose must be given on or after 4 th birthday
MMR:	2 doses separated by at least 28 days, 1 st dose on or after 1 st birthday
Meningococcal:	1 dose
Hep B:	3 doses, last dose on or after 24 weeks of age
Varicella:	2 doses separated by at least 3 months-1 st dose on or after 1 st birthday; or verification of disease

- DTaP vaccine is not given on or after the 7th birthday and may be given for all doses in the primary series.
- Tdap can be given in lieu of Td vaccine for children 7 years and older unless contraindicated. Tdap is only licensed for one dose.
- Hib is not required for children 5 years of age or older.
- Pneumococcal is required for all Pre-K and K students less than 5 years of age.
- Hep A requirement for school year 2017-18 applies to all Pre-K, K, 1st, 2nd, 3rd, 4th & 5th graders born 1/1/07 or later.
- Hep B requirement for school year 2017-2018 applies to all students in grades K-12.
Spacing intervals for a valid Hep B series: at least 4 weeks between doses 1 and 2; 8 weeks between doses 2 and 3; at least 16 weeks between doses 1 and 3; dose 3 should not be given before 24 weeks of age.
- Second MMR for school year 2017-2018 applies to all students in grades K-12.
- Meningococcal Conjugate requirement for school year 2017-18 applies to all students in grades 7-12
- Tdap requirement for school year 2017-18 applies to all students in grades 7-12
- If two live virus vaccines (MMR, Varicella, MMRV, Intra-nasal Influenza) are not administered on the same day, they must be separated by at least 28 days (there is no 4 day grace period for live virus vaccines). If they are not separated by at least 28 days, the vaccine administered second must be repeated.
- Lab confirmation of immunity is only acceptable for Hep A, Hep B, Measles, Mumps, Rubella, and Varicella.
- **VERIFICATION OF VARICELLA DISEASE:** Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.
- For the full legal requirements for school entry visit www.ct.gov/dph/cwp/view.asp?a=3136&Q=467374&PM=1
- If you are unsure if a child is in compliance, please call the Immunization Program at (860) 509-7929.

New Entrant Definition:

*New entrants are any students who are new to the school district, including all preschoolers and all students coming in from Connecticut private, parochial and charter schools located in the same or another community. All pre-schoolers, as well as all students entering kindergarten, including those repeating kindergarten, and those moving from any public or private pre-school program, even in the same school district, are considered new entrants. The one exception is students returning from private approved special education placements—they are not considered new entrants.

Commonly Administered Vaccines:

<u>Vaccine:</u>	<u>Brand Name:</u>	<u>Vaccine:</u>	<u>Brand Name:</u>
DTaP-IPV-Hib	Pentacel	MMRV	ProQuad
DTaP-HIB	TriHibit	PCV7	Pevnar
HIB-Hep B	Comvax	PCV13	Pevnar 13
DTaP-IPV-Hep B	Pediarix	DTaP-IPV	Kinrix
Hepatitis A	Havrix, Vaqta	Influenza	Fluzone, FluMist, Fluviron, Fluarix, FluLaval



State of Connecticut Department of Education

Health Assessment Record



To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	<input type="checkbox"/> Black, not of Hispanic origin
Primary Care Provider	<input type="checkbox"/> American Indian/ Alaskan Native	<input type="checkbox"/> White, not of Hispanic origin
	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian/Pacific Islander
		<input type="checkbox"/> Other
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N		
Does your child have dental insurance? Y N		

If your child does not have health insurance, call 1-877-CT-HUSKY

* If applicable

Part I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)						Diabetes	Y	N
Any immediate family members have high cholesterol						ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any medications your child will need to take in school:

All medications taken in school require a separate Medication Authorization Form signed by a health care provider and parent/guardian.

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.	Signature of Parent/Guardian	Date
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Part II — Medical Evaluation

HAR-3 REV. 4/2011

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

*Height _____ in. / _____% *Weight _____ lbs. / _____% BMI _____ / _____% Pulse _____ *Blood Pressure _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen			*Postural <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made		
Genitalia/ hernia					
Skin					

Screenings

*Vision Screening	*Auditory Screening	Lead:	Date
Type: <u>Right</u> <u>Left</u> With glasses 20/ 20/ Without glasses 20/ 20/ <input type="checkbox"/> Referral made	Type: <u>Right</u> <u>Left</u> <input type="checkbox"/> Pass <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Fail <input type="checkbox"/> Referral made		
		*HCT/HGB:	
		*Speech (school entry only)	
		Other:	

TB: High-risk group? No Yes PPD date read: _____ Results: _____ Treatment: _____

*IMMUNIZATIONS

Up to Date or Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

*Chronic Disease Assessment:

Asthma No Yes: Intermittent Mild Persistent Moderate Persistent Severe Persistent Exercise induced
If yes, please provide a copy of the Asthma Action Plan to School

Anaphylaxis No Yes: Food Insects Latex Unknown source

Allergies *If yes, please provide a copy of the Emergency Allergy Plan to School*

History of Anaphylaxis No Yes Epi Pen required No Yes

Diabetes No Yes: Type I Type II **Other Chronic Disease:** _____

Seizures No Yes, type: _____

This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
 Explain: _____

Daily Medications (specify): _____

This student may: participate fully in the school program
 participate in the school program with the following restriction/adaptation: _____

This student may: participate fully in athletic activities and competitive sports
 participate in athletic activities and competitive sports with the following restriction/adaptation: _____

Yes No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
 Is this the student's medical home? Yes No I would like to discuss information in this report with the school nurse.

Signature of health care provider	MD / DO / APRN / PA	Date Signed	Printed/Stamped Provider Name and Phone Number
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Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*					Required for 7th grade entry
IPV/OPV	*	*	*			
MMR	*	*				Required K-12th grade
Measles	*	*				Required K-12th grade
Mumps	*	*				Required K-12th grade
Rubella	*	*				Required K-12th grade
HIB	*					PK and K (Students under age 5)
Hep A	*	*				PK and K (born 1/1/2007 or later)
Hep B	*	*	*			Required PK-12th grade
Varicella	*	*				2 doses required for K & 7th grade as of 8/1/2011
PCV	*					PK and K (born 1/1/2007 or later)
Meningococcal	*					Required for 7th grade entry
HPV						
Flu	*					PK students 24-59 months old – given annually
Other						

Disease Hx _____ (Specify) _____ (Date) _____ (Confirmed by)

Exemption

Religious _____ Medical: Permanent _____ Temporary _____ Date _____
 Recertify Date _____ Recertify Date _____ Recertify Date _____

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN

- DTaP: At least 4 doses. The last dose must be given on or after 4th birthday.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart – 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after 1st birthday (Children 5 years and older do not need proof of Hib vaccination).
- Pneumococcal: 1 dose on or after 1st birthday (born 1/1/2007 or later and less than 5 years old).
- Hep A: 2 doses given six months apart-1st dose on or after 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students enrolled before August 1, 2011, 1 dose given on or after 1st birthday; for students enrolled on or after August 1, 2011 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 1-6

- DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday;

- students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
 - MMR: 2 doses given at least 28 days apart- 1st dose on or after the 1st birthday.
 - Hep B: 3 doses – the last dose on or after 24 weeks of age.
 - Varicella: 1 dose on or after the 1st birthday or verification of disease*.

GRADE 7

- Tdap/Td: 1 dose of Tdap for students 11 yrs. or older enrolled in 7th grade who completed their primary DTaP series; For those students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are needed, one of which must be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart – 1st dose on or after the 1st birthday.
- Meningococcal: one dose for students enrolled in 7th grade.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.

- Varicella: 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 8-12

- Td: At least 3 doses. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine one of which should be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart- 1st dose on or after the 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart or verification of disease*.

* Verification of disease: Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations require an authorized prescriber's (i.e. physician, dentist, APRN, physician assistant) written order and parent or guardian's authorization for a nurse to administer medications or in her absence, the principal or teacher to administer medications. Medications must be in pharmacy prepared containers and labeled with name of child, name of drug, strength, dosage, frequency, Authorized prescriber's name and date of original prescription.

Physician or Dentist's Order

Name of Child _____ Date _____
Address _____ Date of Birth _____
Condition for which drug is being administered during school hours _____

Name of Medication _____ Dosage _____
Time of administration _____
Medication shall be administered from _____ to _____
(Date) (Date)

If inhaler or Epipen may self administer Yes _____ or No _____
Relevant side effects to be observed, if any _____
If there are side effects, plan for management _____

Is this a controlled drug? _____ If yes, DEA number _____
Authorized prescriber's name _____ Date _____
Address _____
Authorized Prescriber's signature _____

AUTHORIZATION BY PARENT/GUARDIAN for administration of the above medication by school personnel: Date _____

To School Personnel:

I hereby request that the above medication, ordered by the authorized prescriber for my child _____, be administered by school personnel. I understand that must properly labeled by an authorized prescriber or pharmacist and will provide no more than a 45 school day supply of said medication.

I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Name _____
(Type or Print)

Signature: _____ Relationship to child _____

ADMINISTRATION OF MEDICATION AT SCHOOL

State Law (C.G.S. 10-212a) regulates the use of medication by students enrolled in public schools and includes those medications prescribed by a Physician, Dentist, Optometrist, Advanced Practice Registered Nurse, or Physician's Assistant *and* over-the counter medications. Whenever necessary, students may take over-the-counter and/or prescription medication in school. There are just a few important steps which must be followed to insure the safety and well-being of all students:

- An authorization form must be filled out and signed by the prescribing Physician, Dentist, Advanced Practice Registered Nurse, or Physician's Assistant and the parent/guardian for over-the counter as well as prescription medication. The form (which may be obtained from the school nurse) must come to school with the medication.
- The medication must come to school in the properly labeled original container.
- Medication is to be brought to school by a parent or another responsible adult and delivered to the School Nurse.
- Students may not carry any medication on their person or keep any medication in their locker, either over-the counter preparations or prescription medications. The only exceptions are an inhaler and an Epi-pen which some students must have immediately available because of a life-threatening medical condition. This circumstance requires prior arrangement with the authorized Prescriber and the School Nurse.
- Any remaining medication must be picked up from school by a parent or responsible adult within 5 days after the completion of the order or the medication must be discarded.

If you have any questions about medication use at school, please do not hesitate to call the School Nurse.