ARCHBISHOP WILLIAMS
HIGH SCHOOL · GRADES 7 – 12

HEALTH INFORMATION FOR SCHOOL YEAR | 2023 - 2024

Dear Parent/Guardian:

Archbishop Williams school nurses play an essential role in keeping students healthy, safe and ready to learn. We coordinate health services between the school, home and outside physicians to provide the best possible healthcare for your child. It is essential that we be aware of the specific health needs, physical limitations and social or emotional concerns that influence your child's performance while attending Archbishop Williams. Please share with us any information that you feel will be beneficial to school personnel as we work closely with your child.

State Mandated Information

An in-person physical exam and immunization record is required to be submitted to the Student Health Office through the Magnus Health Portal by August 18, 2023 for all newly admitted students, and students beginning tenth grade. The physical must be dated within one year. Also, please contact your child's previous school and have all health records forwarded to us at the end of this school year. The following immunizations must be documented in compliance with the Massachusetts General Laws, or a Medical or Religious exemption may be submitted annually to the Student Health Office:

Grades 7 – 12†

In ungraded classrooms, Grade 7 requirements apply to all students ≥12 years.

Tdap	**1 dose;** and history of DTaP primary series or age appropriate catch-up vaccination. Tdap given at ≥7 years may be counted, but a dose at age 11-12 is recommended if Tdap was given earlier as part of a catch-up schedule. Td or Tdap should be given if it has been ≥10 years since last Tdap
Polio	**4 doses;** fourth dose must be given on or after the 4th birthday and ≥6 months after the previous dose, or a fifth dose is required. 3 doses are acceptable if the third dose is given on or after the 4th birthday and ≥6 months after the previous dose
Hepatitis B	**3 doses;** laboratory evidence of immunity acceptable. 2 doses of Heplisav-B given on or after 18 years of age are acceptable
MMR	**2 doses;** first dose must be given on or after the 1st birthday and second dose must be given ≥28 days after first dose; laboratory evidence of immunity acceptable
Varicella	**2 doses;** first dose must be given on or after the 1st birthday and second dose must be given ≥28 days after first dose; a reliable history of chickenpox* or laboratory evidence of immunity acceptable

NEW – Meningococcal Requirements

Grade 7	**1 dose**; 1 dose MenACWY (formerly MCV4) required. Meningococcal B vaccine is not required and does not meet this requirement.
Grade 11‡	**2 doses**; second dose MenACWY (formerly MCV4) must be given on or after the 16th birthday and ≥ 8 weeks after the previous dose. 1 dose is acceptable if it was given on or after the 16th birthday. Meningococcal B vaccine is not required and does not meet this requirement.

MIAA Sports Physicals

MIAA requires that all students that wish to try out, practice, or play a sport must have a current (within thirteen months) physical exam on file with the Student Health Office stating clearance to participate. If the physical exam expires during the sports season, the student must have a new physical on file prior to the expiration date to continue their participation in the sport.

Medications

Archbishop Williams High School policy requires that a licensed physician provide a medication order for prescription medications to be administered by the school nurse. Parents/guardians may give authorization to administer Acetaminophen, Ibuprofen, Benadryl, and Antacids through their student's Magnus Health Portal.

- All medications must be brought to the school by a parent/guardian in the original labeled container, and the container must be left in the Student Health Office.
- An individual medication plan will be developed and must be signed by both the parent/guardian and nurse. Only a 30-day supply of medication may be kept at school. *No child is permitted to bring medications to school or carry medication in school with the exception of an inhaler, Epinephrine auto injector or if wearing an insulin delivery system (pump).* Students may carry their own inhaler &/or Epinephrine auto injector and/or insulin delivery system only after contacting the school nurse and providing a physician medication order form and parental permission form. Call your school nurse for more information.

Injuries and Illness

- If your child becomes ill while at school, we will assess the student and determine whether they are able to return to class or be dismissed. Please ensure contact information is up to date in Blackbaud and Magnus Health.
- If you wish to dismiss your student, you can do so at any time through SchoolPass and the Student Life Office.
- Injuries at school, if severe, will be handled as an emergency situation and local EMS will be called to take your child to the most appropriate receiving hospital. Parents will be notified immediately if an ambulance is called.
- If an injury occurs in, or out of school that requires special accommodations, please notify the Student Health Office as soon as possible and provide written documentation from a physician. Written documentation is required for return to normal activity as well.

We look forward to starting a new year at Archbishop Williams High School and if you have any questions or concerns please do not hesitate to contact us!

Sincerely,
Student Health Services
80 Independence Ave., Braintree, MA 02184
Email: nurses@awhs.org
Phone: 781-843-3636 ext. 1421/1422
Fax: 781-884-9431
https://secure.magnushealthportal.coM

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name _____ ☐ Male ☐ Female Date of Birth:_____
Medical History _____
_____

Pertinent Family History

Current Health Issues

Y	N	
☐	☐	Allergies: Please list: Medications _____ Food _____ Other _____
		History of Anaphylaxis to _____ Epi -Pen®: ☐ Yes ☐ No
☐	☐	Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)
☐	☐	Diabetes: ☐ Type I ☐ Type II
☐	☐	Seizure disorder: _____
☐	☐	Other (*Please specify)* _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:**_____

Hgt: _____(_____%) Wgt:_____(_____%) BMI: _____(_____%) BP: _____
(Check = Normal / If abnormal, please describe.)

☐ General _____	☐ Lungs _____	☐ Extremities _____
☐ Skin _____	☐ Heart _____	☐ Neurologic _____
☐ HEENT _____	☐ Abdomen _____	☐ Other _____
☐ Dental/Oral _____	☐ Genitalia _____	

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other_____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
TB Test Type: ☐ TST ☐ IGRA Date: _____ Result: ☐Positive ☐Negative ☐Indeterminate/Borderline
Referred for evaluation to: _____ Date:_____ ☐ Low risk (no TB test done)

This student has the following problems that may impact his/her educational experience:
☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations:_____

☐Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** _____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record**.

_____ _____
Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____
Group Practice Telephone

_____
Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 08/15/13*

CERTIFICATE OF IMMUNIZATION

Name: **Date of Birth: / / Gender:**

Please indicate vaccine type (e.g., DTaP-Hib, etc.), not brand name.

Vaccine		Date	Vaccine Type	Vaccine		Date	Vaccine Type
Hepatitis B (e.g., HepB, Hep B-CpG, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1			**Measles, Mumps, Rubella** (e.g., MMR, MMRV)	1		
	2				2		
	3			**Varicella** (Var, MMRV)	1		
	4				2		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1			**Meningococcal Quadrivalent** MenACWY-Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2				2		
	3			**Meningococcal Serogroup B (Men B)** MenB-FHbp (Trumenba) MenB-4C (Bexsero)	1		
	4				2		
	5				3		
	6			**Seasonal Influenza** Inactivated (e.g., IIV4, RIV4, ccIIV4, IIV3, IIV3-HD, aIIV3, RIV3, IIV4-ID) Live Attenuated (e.g., LAIV, LAIV4)	1		
	7				2		
	8				3		
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1				4		
	2				5		
	3				6		
	4				7		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1			**2009 H1N1 Influenza** Inactivated or Live	1		
	2				2		
	3			**Pneumococcal Polysaccharide** (PPSV23)	1		
	4				2		
	5			**Hepatitis A** (HepA, HepA-HepB)	1		
Pneumococcal Conjugate (PCV13, PCV7)	1				2		
	2			**Human Papillomavirus** (9vHPV, 4vHPV, 2vHPV)	1		
	3				2		
	4				3		
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1			**Zoster** (Shingles) (RZV [Shingrix], ZVL [Zostavax])	1		
	2				2		
	3				3		

Please see next page ➡

CERTIFICATE OF IMMUNIZATION (continued)

Please indicate vaccine type (e.g., DTaP-Hib, etc.), not brand name.

Other Vaccines:

Vaccine Type	Dose No.	Date

Serologic Evidence of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic evidence of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)*: **Date:** / /

Signature:

Facility name: