LEAP SCHOOL MEDICAL INFORMATION

We must receive a current physical form that is completed by your child's pediatrician to complete your child's enrollment at LEAP. Your pediatrician's standard "camp form" may be used in lieu of this Massachusetts School Health Record From.
If you need to supply the doctor with a form, you can provide them the form that is on the back of this letter.

The ***minimum*** immunization requirements for preschool age children are as follows:
<u>These immunizations are required by the state in order for you child to attend school.</u>

<u>By two years:</u>
Recent physical within 1 year
4 doses of DTP
3 doses of Polio
3 doses of HEP B
1-4 doses of Hib
1 dose of MMR
Lead Screening
1 dose of Varicella
or a reliable history of chickenpox
(must be physician-certified)

** Exemptions for immunizations can only be given if there is a Medical or Religious objection.*
In such cases, a signed statement from the doctor <u>must</u> be presented to LEAP with the medical forms.
Please feel free to call Jaclyn Lopes in the admissions office with any questions, #781-861-1026.

** Per the Massachusetts Department of Public Health: If there is an outbreak of chicken pox, susceptible students who are in close contact with the disease who are not appropriately immunized or are without laboratory evidence of immunity or a reliable history of chicken pox, shall be excluded from school from the 10th through the 21st days after their last exposure.*

If you would like to have your doctor's office fax it to the LEAP School, please have them fax it to the LEAP Admissions office at #781-860-9525 (Attn: Jaclyn Lopes)
A parent must call us to confirm that we have received the fax.

PLEASE NOTE:
YOUR PEDIATRICIAN'S STANDARD "CAMP FORM" MAY BE USED IN LIEU OF THIS FORM

MASSACHUSETTS SCHOOL HEALTH RECORD

Child's Name: _____ Sex: _____ Date of Birth:_____

Address:_____ School: The LEAP School

IMMUNIZATIONS REQUIRED

Type of immunization	***Date***	***Date***	***Date***	***Date***
Hib				
Trivalent Sabin Vac. (Polio)				
DTP (Diptheria, Tetanus, Pertussis)				
MMR (Measles, Mumps,Rubella)				
Hepatitis B				
Varicella (chickenpox)				
Lead Screen *Date* & *Result*				
Most recent Physical Exam Date				

MEDICAL HISTORY (Give Dates)

☐ Accidents	☐ Allergy	☐ Congenital Anomaly	☐ Convulsions	☐ Ear Infections
☐ Encephalitis	☐ Diabetes	☐ Heart Disease	☐ Hernia	☐ Kidney Disease
☐ Measles	☐ Meningitis	☐ Mumps	☐ Operations	☐ Poliomyelitis
☐ Rheumatic Fever	☐ Rubella	☐ Scarlet Fever	☐ Strep Throat	☐ Tonsillitis
☐ Tuberculosis	☐ Whooping Cough	☐ Other		
☐ Chicken Pox History				

_____

Pertinent Family Medical History:

Does this child have any disabilities or chronic medical problems (allergies, limited vision/hearing, etc.) which require special consideration or care by the child care provider? If so, please detail below:

⇒ _____ _____

Physician's Signature **Date:**