

Dear Parent /Guardian:

DUE NO LATER THAN CHILD'S FIRST DAY OF SCHOOL

The state requires all new students provide the school with a complete immunization record and physical completed by a physician.

Students cannot begin school without documentation that all health requirements have been satisfied.

If your child has an appointment with the doctor past this date, a note from the doctor or appointment card with the date of exam is required before the first day of school.

Please submit the required documentation no later than the child's first day of school or your child **will be excluded** from school until the documentation is received.

Thank you for your cooperation.

School Nurse

Dear Parent/Guardian:

In order to provide your child with the best medical attention and to meet the State Requirements for school admission, the following paperwork must be brought to registration or submitted before the first day of school.

*** All immunizations must be documented by your child's Doctor.***

PRE-K (3 and 4 year old children)

DPT – 4 doses

POLIO – 3 doses

MMR – 1 dose - given on or after 1st birthday

HIB – 1-4 doses, one dose given at 12 months of age or later

VARICELLA – 1 dose given on or after 1st birthday; or date of disease (chicken pox)

PNEUMOCOCCAL Conjugate Vaccine series

INFLUENZA -- 1 dose – *annually* between September 1 and December 31st.

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KINDERGARTEN THROUGH 12th GRADE

DPT – A minimum of 4 doses, one dose must have been on or after 4th birthday. A total of any 5 appropriately spaced doses is also satisfactory. If vaccine not started until 7th birthday, 3 doses of appropriately spaced Td are required.

POLIO – A minimum of 3 doses, one dose must have been given on or after 4th birthday.
A total of any 4 appropriately spaced doses is also satisfactory.

MMR – 2 doses: The first must be on or after 1st birthday.

HEPATITIS B – 3 doses (There is a 2 dose vaccine which can be given between ages 11 & 15 but this must be documented by the physician).

VARICELLA – for students entering Kindergarten and 1st grade – 1 dose given on or after 1st birthday; or date of disease (chicken pox). If transferring into a New Jersey school from another state or country, vaccine (or date of Disease) is required for those born on or after 1/1/98.

Tdap and MENACTRA – 1 dose of each for students entering 6th grade.

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Physical Examination

Required for students entering preschool, Kindergarten and those transferring from out of State or Country.

The physical must be completed no more than 365 days prior to entry into school/grade.

Student Health History

Completed by parent/guardian.

Permission Form for Health Screenings

Medication

If a medication, prescription or over-the-counter, is to be administered in school, a medication administration permission form must be signed by the parent/guardian and physician. You can request this form from the nurse or school office. These forms, along with the medication in the original box or bottle, need to be brought to school in the beginning of each school year.

If you have any questions, please call the school nurse. Thank you for your cooperation.

Student Health Inventory

Teacher _____ Grade _____ School _____

Your child's learning depends upon good health. To assist in providing health services at school, please complete the following and return this to the School Nurse.

Name _____ Birthdate _____ Boy Girl
Last First Middle

Parent/Guardian _____ Phone # _____

Parent's employment _____
Father Phone Mother Phone

Emergency Contacts _____
(Other than parent) Name Phone Name Phone

Last School attended _____
Name City State

Doctor's name _____ Date of last physical _____

Dentist's name _____ Date of last exam _____

Is student under an orthodontist's care? Yes No Doctor's name _____

Does student have:

Allergies? Yes No To drugs, food, insects, pollen? Please list _____
 Has the allergy required emergency action in the past? Yes No
 Comments _____

Bee sting allergy? Yes No Describe reaction _____
 Difficult breathing? Yes No Need emergency medication? Yes No

Asthma? Yes No Triggered by _____ Treatment _____
 Diagnosed by doctor _____ Date _____

Diabetes? Yes No Takes insulin? Yes No Date Diagnosed _____

Epilepsy/Seizures Yes No Describe seizure _____
 Date of last seizure _____ Medication _____
 Is student currently under a doctor's care for seizures? Yes No

Heart condition? Yes No Describe _____
 Any physical restrictions? _____ Medication? Yes No

Bone or joint problems? Yes No Describe _____
 Any physical restrictions? _____

Check off the following regarding health concerns that pertain to student:

Eyes: Glasses Contacts Difficulty seeing **Ears:** Frequent Infections Hearing Aid
 Reading Crossed Lazy Eye Tubes Right Left
 Distance Hearing difficulty, explain Wear at School
 Other

Other: nosebleeds eating sleeping bladder skin phobias bedwetting
 lungs neurologic headaches bowel dental ADD/ADHD

Daily medication at home? Yes No At school? Yes No Emergency only? Yes No

Name of medication and reason for taking _____

List serious illness or injuries _____

Surgeries (operations) _____ Condition that prevents PE participation _____

Other health information or concerns _____

If student requires medication at school, or a change in PE participation, please obtain the appropriate form in the school office.

MEDICAL PERMISSION FOR SCHOOL HEALTH SERVICES

STUDENT'S NAME _____ **GRADE** _____

I hereby give permission for my child to receive the following medical attention as part of the school health program:

- 1. Height and weight**
- 2. Vision screening**
- 3. Hearing screening**
- 4. Scoliosis screening in 5th, 7th, 9th and 11th grade**
- 5. Blood pressure**

I also give permission for my child's medical information to be shared with the appropriate teachers if necessary for his/her safety and well being.

This Medical Permission Form allows your child to participate in the School Health Program. It will cover your child through 12th grade. It will be incorporated into your child's health records.

You will still be notified before the scoliosis screening and may withdraw permission for any procedure at any time.

PARENT'S SIGNATURE _____ **DATE** _____