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.

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.

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.

PRE-SCHOOL PHYSICAL EXAMINATION AND IMMUNIZATION RECORD

Name _____ Date of Birth _____

Physical examination record

Height_____ Weight_____

Blood pressure_____ Pulse_____

Vision (r)_____(l)_____ Hearing (r)_____(l)_____

Eyes_____ Lungs_____

Ears, Nose, Throat_____ Abdomen_____

Mouth and teeth_____ Skin_____

Neck_____ Genitals/Hernia_____

Heart_____ Extremities_____

Allergies_____ Restrictions from activities_____

Recommendations:_____

_____

Pre-school immunizations ** Required*

8 is *recommended* for pre-school entrance (will be required for **kindergarten**).

Type of Vaccine	Dose 1	Dose 2	Dose 3	Boosters
1 DPT/DTaP	*	*	*	*
2 POLIO	*	*	*	
3 MMR	*			
4 VARICELLA (chicken pox)	* one dose *or* disease			
5 HIB	*			
6 INFLUENZA (before Dec. 31st)	*			
7 PNEUMOCOCCAL 8 # Hepatitis B	*			

*Doctor's Name (PRINT)*_____

*Doctor's Address*_____ *Telephone*_____

*Doctor's Signature*_____ *Date of Exam*_____

_____

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
☐ Reading ☐ Crossed ☐ Lazy Eye
☐ Distance

Ears: ☐ Frequent Infections ☐ Tubes ☐ Hearing difficulty, explain
Hearing Aid ☐ Right ☐ Left ☐ 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.

The Camden County School Nurse program for non-public schools is administered by the Southern NJ Perinatal Cooperative.