KINDERGARTEN REQUIREMENTS

New Jersey Board of Education and the New Jersey Department of Health and Senior Services require that all children entering kindergarten have:

1. Physical and Health History (the physical must be completed no more than 365 days prior to entry into school).
2. An up-to-date immunization record with the following requirements:
   - DPT—4 doses including one after the child's 4th birthday or 5 doses any age.
   - Polio—3 doses including one after the child's 4th birthday or 4 doses any age.
   - MMR—2 doses: the first must be given on or after 1st birthday.
   - Hepatitis B—3 doses.
   - Varicella—one dose given on or after 1st birthday or date of disease.

These requirements MUST be submitted before your child begins school or your child WILL BE EXCLUDED from school until documentation is received.

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

ANY medication to be administered in school MUST have a medication administration form signed by the parent/guardian and physician. These forms, along with the medication in the original container, need to be brought into school by an adult in the beginning of each school year.

Thank you for your cooperation.

School Nurse

Grade _____

STATE OF NEW JERSEY
HEALTH HISTORY AND APPRAISAL

IMMUNIZATION REGISTRY NUMBER

Name of Child (Last, First, M.I.) | Date of Birth (Mo/Day/Yr) | Sex ☐ Male ☐ Female

PARENT OR GUARDIAN — NAME | TELEPHONE NO.

ADDRESS

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination *(If Td or DT, indicate in corner box)*					
Tdap					
POLIO – INACTIVATED POLIO VACCINE (IPV) *If oral vaccine, indicate (OPV) in corner box*					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB)**					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE **					
MENINGOCOCCAL					
HEPATITIS A ***					
HPV (HUMAN PAPILLOMAVIRUS) ***					
OTHER					

LEAD SCREENING	
Test Date	Result

Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

TB Mantoux Date_____ Read_____ Results_____

Measles, Mumps and Rubella Vaccine (MMR) all students shall have received two doses of a measles containing vaccine or any vaccine combination containing live measles vaccine such as the preferred measles, mumps, and rubella.

Diphtheria, Tetanus and Pertussis (DPT)-every child less than 7 years shall have received four doses of DPT, one of which must have been administered on or after the 4th birthday. A child with any total of 5 doses of DPT is in compliance with this regulation.

Poliovirus Vaccine – every child less than 7 years shall have received a minimum of 3 doses of poliovirus vaccine, one dose of which shall have been given on or after the child's 4th birthday. Any appropriately spaced combination of 4 doses is also in compliance with this regulation.

Hepatitis B Vaccine – every child entering Kindergarten or 1st grade, shall have received 3 doses of hepatitis B vaccine prior to school entrance.

Varicella Vaccine(chicken pox) or Date of Disease –every child entering kindergarten must have received one dose of Varicella vaccine or provide a statement of previous varicella disease.

Tdap –all children entering grade 6 shall have received one dose of Tdap (Tetanus, diphtheria, acellular pertussis) given no earlier than the 10th birthday and not less than 5 years from the last documented Td dose.

Meningococcal Vaccine – every child entering 6th grade after and 11 years of age shall have received one dose of meningococcal –containing vaccine.

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Asthma? _____ Allergies _____

*Height*_____ *Mouth & Throat*_____ *Skin*_____

*Weight*_____ *Chest & Lungs*_____ *Posture/Spine/Gait*_____

*Nutrition*_____ *Heart*_____ *Scalp/Head/Neck*_____

*Abdomen/Hernia*_____ *Genitals*_____ *Coordination*_____

*Extremities*_____ *Eyes*_____ *Last Eye Exam*_____

*Nose*_____ *Ears*_____ *Last Hearing Exam*_____

*Blood Pressure*_____ *Any Restrictions*_____ *Any Referrals Needed?*_____

*medication*_____

*Physician– Print Name*_____ *Address:*_____

*Physician Signature:*_____ *Date:*_____

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.

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_____