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.

PRIVATE PHYSICIAN'S EXAMINATION REPORT

Student's Name_____ DOB_____

Examining Physician_____
(Print)

Date of Exam _____ Physician's Phone Number_____

Height_____ Weight_____ Blood Pressure_____

Scalp, Head, Neck_____

Eyes_____ Last Eye Exam_____

Ears_____ Last Hearing Exam_____

Nose_____

Mouth and Throat_____

Chest and Lungs_____

Heart_____

Abdomen, Hernia_____

Genitals_____

Extremities_____

Skin_____

Posture, Gait, Spine_____

Coordination_____

Blood Pressure_____

Restrictions_____

Referral Needed YES_____ NO____

Immunizations_____***Please attach shot record***

**6th grade students: Meningococcal vaccine Date_____

Tdap Date_____

Physician's Signature _____

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 ☐ Reading ☐ Distance ☐ Contacts ☐ Crossed ☐ Difficulty seeing ☐ Lazy Eye

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.