

**IMPORTANT NOTICE TO ALL KINDERGARTEN PARENTS
FROM THE NURSES' OFFICE**

Dear Parent(s)/Guardians:

Per NJ State Law, all students must have the following **by the first day of school**:

1. A complete medical packet which can be downloaded from our school website. This must be completed in its entirety by **BOTH a physician and a parent. This includes a permission form, student health inventory, a physical within 365 days of the first day of school, and the following items).**
2. A complete immunization record (requirements are listed on our medical packet). By state law a child **can be excluded** from school if this is not up to date.
3. If your child has a severe allergy and requires an Epi-auto-injector and/or Benadryl. A complete packet and the medicine must be sent in by the first day of school. A **physician and parent** must fill these forms out. This also can be downloaded from our website.
4. If your child has asthma and may require an inhaler or nebulizer treatment at school, an asthma packet must be filled out, medicine sent in, and **signed by Both a physician and parent.** Again, the packet can be downloaded from our website.
5. If your child requires **ANY** medicine in school (**EVEN OVER THE COUNTER MEDICINE**) a **physician and parent** must fill out a form found on our website and send in the medicine in its original packaging.

Thank you for your cooperation in these matters. Your child's well-being is a priority to us.

See you in September!

The School Nurses

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: <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Difficulty seeing <input type="checkbox"/> Reading <input type="checkbox"/> Crossed <input type="checkbox"/> Lazy Eye <input type="checkbox"/> Distance | Ears: <input type="checkbox"/> Frequent Infections <input type="checkbox"/> Tubes <input type="checkbox"/> Hearing difficulty, explain <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Wear at School <input type="checkbox"/> 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.

MEDICAL PERMISSION
for
SCHOOL HEALTH SERVICES

Child'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 and 7th grades
5. Blood Pressure Screening

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.

Parent's Signature

Date

This Medical Permission Form allows your child to participate in the School Health Program. It will cover your child through the 8th 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.