IMMUNIZATION AND HEALTH HISTORY RECORDS

Child's Name _____

Immunizations (Copies of immunizations may be attached)

***DPT**

Date _____ (1st dose) Date _____ (2nd dose) Date _____ (3rd dose)

Date _____ (4th dose) Date _____ (5th dose)

***Polio Immunization**

Date _____ (1st dose) Date _____ (2nd dose) Date _____ (3rd dose)

Date _____ (4th dose)

***Measles/Mumps/Rubella Vaccine** (To be given on or after the 1st birthday) Date _____

* 2nd Measles __ or MMR Vaccine __ (Doses must be separated by at least one month) Date _____

****Pneumococcal Conjugate Vaccine (minimum of one dose after the 1st birthday)**

Date _____ (1st dose) Date _____ (2nd dose) Date _____ (3rd dose)

Date _____ (4th dose)

****Haemophilus B (Hib) Vaccine (minimum of one dose after the 1st birthday)**

Date _____ (1st dose) Date _____ (2nd dose) Date _____ (3rd dose)

Date _____ (4th dose)

***Hepatitis B**

Date_____ Date_____ Date_____

***Varicella (minimum of one dose on or after the 1st birthday)** Date_____ Date_____

Other immunizations

_____ _____ _____ _____

TB Screening (Mantoux) Date _____ Results _____

***Indicates mandatory immunizations – include the month, date, and year.**

****Indicates ADDITIONAL mandatory immunizations for students enrolled in PRESCHOOL-include month, date, and year.**

*****For all students attending PRESCHOOL : The New Jersey Department of Health and Senior Services requires all children age 6 months through 59 months of age attending a day care or preschool program to receive a seasonal flu vaccine between September 1 and December 31 of each year. All students must receive the flu vaccine and provide documentation of such by 12/31/2015 in order to be readmitted to school in January 2016.**

Child's Health History (to be completed by parent/guardian- check and give date)

Seizure Disorder	_____	Poliomyelitis	_____
Strep Infection	_____	Heart Disease	_____
Diabetes	_____	Rheumatic Fever	_____
Measles	_____	Ear Infection	_____
German Measles	_____	Chicken Pox	_____
Whooping Cough	_____	Fifth Disease	_____
Mumps	_____	Contact with TB Carrier	_____
Asthma	_____	ADD/ADHD Dx.	_____
Other	_____		

Please list any further information pertaining to previous illnesses or operations your child may have had:

Allergies Yes_____ No_____ If yes, PLEASE LIST: _____

Does your child require the use of epinephrine (Epi-Pen) for severe (anaphylactic) allergic reaction for any allergies mentioned above?

Yes (please list allergies for which epinephrine use is required) _____

No_____

Please check below if it is known to you that your child has a problem in any of the following so that we may be aware and provide available help.

Vision _____ Hearing _____ Speech _____

Wears glasses: Yes ____ No ____

Date of last eye examination _____ Name of eye doctor _____

Date of last dental examination _____ Name of dentist _____

Is your child taking any medication? **Yes ____** **No ____**

If yes, please list the name of the medications including dosage and frequency:

Name of family doctor _____ **Telephone Number** _____

Address of doctor _____

Rockaway Borough Public Schools
103 East Main Street
Rockaway, NJ 07866

PRESCHOOL PHYSICAL EXAMINATION FORM

YOUR CHILD MUST HAVE A MEDICAL EXAMINATION NOT MORE THAN 365 DAYS BEFORE THE STARTING DATE OF SCHOOL. THANK YOU FOR YOUR COOPERATION.

PLEASE NOTE: New Jersey requires all children up to 59 months of age attending a preschool program to receive a seasonal flu vaccine by December 31 of each year. All students must receive the flu vaccine and provide documentation of such by 12/31/2015 in order to be readmitted to school in January 2016.

MEDICAL EXAMINATION

Child's Name _____ Birth Date_____

Blood Pressure	_____	Pulse	_____	Nutrition	_____
Height	_____	Weight	_____	BMI	_____
Nose	_____	Spine	_____	Posture	_____
Throat	_____	Chest	_____	Feet	_____
Teeth & Gums	_____	Lungs	_____	Speech	_____
Ears	_____	Heart	_____	Nervous System	_____
Eyes	R_____ L_____	Abdomen	_____	Scalp	_____
Genitals	_____	Skin	_____	Lymph Nodes	_____

Serious illnesses, allergies, operations, medications:

Comments or recommendations:

This child is / is not physically capable of participating in a regular school program, including physical education.

_____ _____
Date Physician's Signature

_____ _____
Physician's Phone # Physician's Printed Name and Address