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 Medical Provider.

**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________________ RECOMMENDATIONS:_________________________

________________________________________________________________________

******************************************************************************

PRE-SCHOOL IMMUNIZATIONS

* REQUIRED

# 8 is recommended for pre-school entrance (will be required for KINDERGARTEN)

<table>
<thead>
<tr>
<th>TYPE OF VACCINE</th>
<th>DOSE 1</th>
<th>DOSE 2</th>
<th>DOSE 3</th>
<th>BOOSTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 DPT/DTaP</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
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<tr>
<td>2 POLIO</td>
<td>*</td>
<td>*</td>
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<td></td>
</tr>
<tr>
<td>3 MMR</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 VARICELLA (chicken pox)</td>
<td>* one dose or disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 HIB</td>
<td>*</td>
<td></td>
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</tr>
<tr>
<td>6 INFLUENZA (before Dec. 31st)</td>
<td>*</td>
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<td></td>
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<tr>
<td>7 PNEUMOCOCCAL</td>
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</tr>
<tr>
<td>8 HEPATITIS B</td>
<td></td>
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</tr>
</tbody>
</table>

DOCTOR’S NAME (PRINT)_____________________________________________________

DOCTOR’S ADDRESS __________________________ TELEPHONE____________________

DOCTOR’S SIGNATURE________________________ DATE OF EXAM_________________
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 for students in 5th and 7th grades.

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 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.

PARENT’S SIGNATURE____________________________________DATE________
Student Health Inventory

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 ☐

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___________
  Describe seizure_____________________________ Medication___________________
  Date of last seizure ________________ Is student currently under a doctor’s care for seizures? Yes ☐ No ☐

- Epilepsy/Seizures Yes ☐ No ☐ Describe______________________________
  Any physical restrictions? ___________________________ Medication? Yes ☐ No ☐
  Date of last seizure _________________
  Medication________________________________________

- Heart condition? Yes ☐ No ☐ Describe__________________________________________
  Any physical restrictions? ____________________________

- 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 ☐

- Ears: Frequent Infections ☐
  Tubes ☐ Hearing difficulty, explain ☐
  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 ☐

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.
New Jersey Department of Education
Health History Update Questionnaire

Name of School: __________________________

To participate on a school-sponsored interscholastic or intramural athletic team or squad, each student whose physical examination was completed more than 90 days prior to the first day of official practice shall provide a health history update questionnaire completed and signed by the student’s parent or guardian.

Student: __________________________ Age: _______ Grade: _______

Date of Last Physical Examination: __________________________ Sport: __________________________

Since the last pre-participation physical examination, has your son/daughter:

1. Been medically advised not to participate in a sport?  Yes  No
   If yes, describe in detail: ____________________________________________

2. Sustained a concussion, been unconscious or lost memory from a blow to the head?  Yes  No
   If yes, explain in detail: ____________________________________________

3. Broken a bone or sprained/strained/dislocated any muscle or joints?  Yes  No
   If yes, describe in detail: ____________________________________________

4. Fainted or “blacked out?”  Yes  No
   If yes, was this during or immediately after exercise?  Yes  No

5. Experienced chest pains, shortness of breath or “racing heart?”  Yes  No
   If yes, explain in detail: ____________________________________________

6. Has there been a recent history of fatigue and unusual tiredness?  Yes  No

7. Been hospitalized or had to go to the emergency room?  Yes  No
   If yes, explain in detail: ____________________________________________

8. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or “heart trouble?”  Yes  No

9. Started or stopped taking any over-the-counter or prescribed medications?  Yes  No

10. Been diagnosed with Coronavirus (COVID-19)?  Yes  No
    If diagnosed with Coronavirus (COVID-19), was your son/daughter symptomatic?  Yes  No
    If diagnosed with Coronavirus (COVID-19), was your son/daughter hospitalized?  Yes  No

11. Has any member of the student-athlete’s household been diagnosed with Coronavirus (COVID-19)?  Yes  No

Date: __________________________ Signature of parent/guardian: __________________________

Please Return Completed Form to the School Nurse’s Office
School Health Program

Medication Administration in Schools

The following rules for the administration of medication in schools applies to BOTH prescription and non-prescription (e.g., Tylenol, cough syrup) medications in the school setting. No medication will be administered unless the following requirements are met.

1. A written order from the physician to include the name of the pupil, name of the medication, dosage, the time the medication is to be administered at school and length of time to be given.
2. A written medication administration form completed by the parent/guardian releasing the school and the school personnel from any liability there of. Medications are administered by a school nurse or designated responsible person. Medication Administration forms are available at the school office and from the school nurse.
3. Medications are to be delivered to the school by the parent/guardian or a designated responsible person.
4. All medication must be in the original container and clearly labeled.
5. Controlled medications (e.g. Ritalin) require a thirty-day physicians renewal.
6. At the end of the school year, medications must be picked up at school by the parent/guardian. Any remaining medication will be destroyed.
7. If self-administration of a medication is prescribed, the parent/guardian and the authorizing physician must complete the medication administration form.

School personnel shall not provide pupils with any medication until all the requirements are met.
SCHOOL HEALTH PROGRAM
MEDICATION ADMINISTRATION FORM

I request that the enclosed medication in the original container be administered to my child as prescribed, and shall release school personnel from all liability. This includes ALL over the counter medication e.g. Tylenol, Ibuprophen, Benadryl, cough syrup etc.

NAME OF CHILD _______________________________  GRADE _______________________________

NAME OF MEDICATION ________________________________________________________________

DOSAGE ____________________________________________________________________________

PURPOSE ____________________________________________________________________________

__________________________________________________________________________________

( parent/guardian signature) ( date)

***********************************************************************************************

TO BE FILLED IN BY SCHOOL NURSE

Prescription # ___________________________ Date _____________________________

Pharmacy ___________ Phone # ___________ Name of Medication ____________________________

Name of Physician _______________ Phone # ________________________________

******************************************************************************

PHYSICIAN'S ORDERS

Name of Patient ________________________________

Name of Medication ________________________________

Date of Prescription ________________________________

Dosage ________________________________

Purpose ________________________________

COMMENTS ________________________________________________________________________

__________________________________________________________________________________

Doctor's Name (please print) __________________ Doctor's Signature __________________ Date __________________

meds form
Dear Parent/Guardian:

As we approach the new flu season, we want to remind you that the seasonal influenza vaccine is the safest and best protection available against the flu.

The State of New Jersey requires all children between 6 and 59 months of age and attending pre-school be immunized with the flu vaccine. This vaccine must be received annually between September 1st and December 31st.

We also encourage you to reinforce the importance of frequent hand washing. This is also a good defense against flu and other infectious pathogens.

Please complete and return this form to the school as soon as you have scheduled the appointment for your child. This will help us maintain a tracking system as to when we can expect to receive the documentation.

If you have any questions, please call the nurse’s office. Thank you for your cooperation.

School Nurse


Child’s Name____________________________________________________________________

Teacher________________________________________________________________________

____________My child has already received the flu vaccine since September 1st.

Attached is the updated immunization record.

____________My child is scheduled to receive the flu vaccine on ______________________

I will send in the updated immunization record after the vaccine is given.