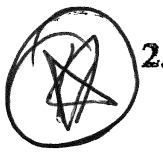
KINDERGARTEN REQUIREMENTS

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:



Please attach!

- 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

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 ☐ lungs ☐ eating ☐ neurologic ☐ sleeping ☐ headaches ☐ bladder ☐ bowel ☐ skin ☐ dental ☐ phobias ☐ ADD/ADHD ☐ bedwetting

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 Regional [illegible]

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.