

Teresa M. Rafferty
Superintendent of Schools
Deborah I. Dawson, Psy.D.
Supervisor of K-8 Counseling and Health Services

Health History/Record Update

Pupil's Name _____
Last First Middle Grade (as of September)

Address _____ Date of Birth _____ Sex _____

Father's Name _____ Home Telephone _____ Cell # _____

Mother's Name _____ Home Telephone _____ Cell # _____

Guardian _____ Home Telephone _____ Cell # _____

The information provided in this update takes the place of any previous information. Health information will be shared with essential staff to assist in your child achieving educational goals.

HEALTH HISTORY	Y	N	DATE	HEALTH HISTORY	Y	N	DATE	HEALTH HISTORY	DATE
Allergy - Specify				Eczema				Injuries/Broken Bones/Stitches (List)	
				Eyeglasses/Contacts					
				Hearing Aid					
				Hearing Difficulties					
				Heart Disease					
Asthma				Hepatitis					
Autism Spectrum Disorder				Hematological Disorder				Operations (List)	
Auto Immune Disorders				Juvenile Rheumatoid Arthritis					
Chronic Otitis Media (Ear Infection)				Lyme Disease					
Congenital Disorder				Mononucleosis					
Convulsive Disorder				Neuromuscular Disorder				Hospitalizations (List)	
Diabetes				Strep Infections					
Drug Allergies - Specify				Other Illnesses - Specify					

MEDICAL RESTRICTIONS (Attach Physician's Note)

CURRENT MEDICATIONS (Prescriptions, Inhaler, EpiPen, etc.)

List all Children in Family (Oldest to Youngest)

Last Name/First Name	Birthdate	Last Name/First Name	Birthdate

Signature of Parent/Guardian _____ Date _____

Any additional information can be attached to this form.

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PHYSICAL EXAMINATION FORM

Pupil's Name _____ Birthdate _____

School _____ Grade _____

Immunizations DTP _____ DT _____ Td _____ Tdap _____

Polio _____ Meningococcal _____

MMR _____ MMR _____ Hep B _____ Heb B _____ Hep B _____

Varicella _____ HIB _____ PCV _____

Pneumococcal Conjugate _____ Influenza _____

Mantoux Tuberculin Skin Test: Date Administered _____ Date Read _____ Results _____ mm

Last Lead Test _____ Lead Test Results _____

Height _____ Weight _____ Blood Pressure _____ Hearing _____ Vision _____

Nutrition _____ Skin _____ Head _____ Eyes _____ Ears _____ Nose _____

Oral (Teeth/Gums) _____ Throat _____ Neck _____ Heart _____ Lungs _____

Abdomen/Hernia _____ Genitalia _____ Extremities _____ Orthopedic _____

Scoliosis _____ Remarks _____ Neurological _____ CBC _____ Urinalysis _____

History of Illness/Injury _____

Medication _____

Participation in Physical Education/Sports/Activities _____

Remarks/Impressions/Summary _____

Physician's Signature _____

Date of Exam _____

Physician's Stamp



FOR CHILD CARE/PRESCHOOL DIRECTORS AND PARENTS: CHILD CARE/PRESCHOOL IMMUNIZATION REQUIREMENTS



**NJ Department of Health
Vaccine Preventable Disease Program**

New Jersey Minimum Immunization Requirements for Child Care/Preschool Attendance
N.J.A.C. 8:57-4 Immunization of Pupils in School

Listed in the chart below are the minimum required number of doses your child must have in order to enroll/attend a child care/preschool facility in NJ. Additional vaccines are recommended by the Advisory Committee on Immunization Practices (ACIP), but only the following are required for child care/preschool attendance in NJ. For the complete ACIP Recommended Immunization Schedule, please visit <http://www.cdc.gov/vaccines/schedules/index.html>.

At this age the child should have received the following vaccines:	2 months	4 months	6 months	12 months	15 months	18 months	19 months	20-59 months
Diphtheria, tetanus & acellular pertussis (DTaP)	Dose #1	Dose #2	Dose #3			Dose #4		
Inactivated Poliovirus (Polio)	Dose #1	Dose #2				Dose#3		
<i>Haemophilus influenzae</i> type b (Hib)	Dose #1	Dose #2		1-4 doses (see footnote)	At least 1 dose given on or after the first birthday	At least 1 dose given on or after the first birthday		
Pneumococcal conjugate (PCV 13)	Dose #1	Dose #2		1-4 doses (see footnote)	At least 1 dose given on or after the first birthday			
Mumps, mumps, rubella (MMR)					Dose #1*			
Varicella (VAR)							Dose #1 †	
Influenza (IIV; LAIV)								One dose due each year †

Interpretation: Children need to receive the minimum number of age-appropriate vaccines prior to entering child care/preschool. For example, a child 2 months of age, must have 1 dose each of DTaP, Polio, Hib, and PCV before being permitted to enter child care/preschool. A child entering at a younger age range than listed above must have proof of receiving vaccines in the previous age bracket. Example: A child entering child care/preschool at 11 months of age, would need at least the following: 3 DTaP, 2 Polio, 2 Hib, and 2 PCV. The current seasonal flu vaccine is required every year by December 31 for children 6-59 months of age.



FOR CHILD CARE/PRESCHOOL DIRECTORS AND PARENTS

* *Haemophilus influenzae* type b (Hib) and pneumococcal (PCV) vaccines are special cases. If a child started late with these vaccines he/she may need fewer doses. One dose of each is required on or after the first birthday in all cases.

Please Note: The use of combination vaccines may allow students to receive the 1st birthday booster dose of Hib between 15-18 months of age.

[†] MMR vaccine may be given as early as 12 months of age, but NJ requires children to receive the vaccine by 15 months of age. Prior to age 15 months, a child may enter preschool/child care without a documented dose of MMR.

[‡] Varicella vaccine may be given as early as 12 months of age, but NJ requires children to receive the vaccine by 19 months of age. Prior to age 19 months, a child may enter preschool/child care without a documented dose of varicella. A child will not have to receive the varicella vaccine if he/she previously had chickenpox as long as the parent can provide the school with one of the following: 1. Documented laboratory evidence showing immunity (protection) from chickenpox, 2. A physician's written statement that the child previously had chickenpox, or 3. A parent's written statement that the child previously had chickenpox.

^{††} The current seasonal influenza vaccine is required every year for those children 6 months through 59 months of age. Students who have not received the flu vaccine by December 31 must be excluded (not allowed to attend child care/preschool) for the duration of influenza season (through March 31), until they receive at least one dose of the influenza vaccine or until they turn 60 months of age. Children enrolling in child care/preschool after December 31, must provide documentation of receiving the current seasonal flu vaccine before being allowed to enter school. Students enrolling in school after March 31 are not required to receive the flu vaccine; however, flu season may extend until May and therefore getting a flu vaccine even late in the season is still protective.

NJ accepts valid medical and religious exemptions (reasons for not showing proof of immunizations) as per the NJ Immunization of Pupils in School regulations, N.J.A.C. 8:57-4. Children without proof of immunity as defined by ACIP, including those with medical and religious exemptions, may be excluded from a school, preschool, or child care facility during a vaccine preventable disease outbreak or threatened outbreak as determined by the Commissioner, Department of Health or his or her designee. In addition, anybody having control of a school may, on account of the prevalence of any communicable disease, or to prevent the spread of communicable disease, prohibit the attendance of any teacher or pupil of any school under their control and specify the time during which the teacher or scholar shall remain away from school. The Department of Health shall provide guidance to the school of the appropriateness of any such prohibition.

For more information, please visit “NJ Immunization Requirements Frequently Asked Questions”, at the following link:

<http://nj.gov/health/cd/imm.shtml>. **Interpretation:** Children need to receive the minimum number of age-appropriate vaccines prior to entering child care/preschool. For example, a child 2 months of age, must have 1 dose each of DTaP, Polio, Hib, and PCV before being permitted to enter child care/preschool. A child entering at a younger age range than listed above must have proof of receiving vaccines in the previous age bracket. Example: A child entering child care/preschool at 11 months of age, would need at least the following: 3 DTaP, 2 Polio, 2 Hib, and 2 PCV. The current seasonal flu vaccine is required every year by December 31 for children 6-59 months of age.



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Dear Parents/Guardians:

Food allergies affect children in many ways, with reactions ranging from itching or a rash to hives and difficulty breathing. If you notify us of your child’s food allergy, food service personnel will be alerted when your child checks out in the food line.

Please complete the form below and return it to the school nurse, who in turn will send the form to Sodexo School Services at the High School (732-981-0700 ext. 2289). **A new form must be completed each school year.** Once the form is returned, the allergy information will be entered into the computer system by Sodexo’s staff. The food allergy information will be entered onto your child’s health record as well. **If your child cannot drink milk and you would like to substitute juice for milk, a doctor’s note is required.** Please attach the note from your child’s doctor to this form when you return it to the nurse.

When your child enters his/her ID number at check out a “Dietary Notice” of food allergies will appear. This alerts food service personnel that this food item should not appear on your child’s tray. If it does, food service personnel will remove the food and talk with your child.

You should be aware, however, that this system may not identify allergens that are ingredients in other foods, such as chicken nuggets or baked goods.

It is hoped that this service will assist with the health and well being of your child. However, this service is not intended to replace parental responsibility for insuring that their child makes appropriate food selections from the school cafeteria.

Sincerely,
Deidre Ortiz
Director of Pupil Services

Jim Giannakis
Sodexo Food Service Manager

Complete and Return to the Nurse at Your Child’s School

A new form must be completed each school year.

* * * * *

Child’s Name ID Number School Grade

___ My Child has the following **food allergies** (do not include personal, religious or cultural preference):

___ My child has no food allergies.

I understand that this information will be entered into the Sodexo School Services system and onto my child’s health record.

Signature of Parent/Guardian Date

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MEDICATION ADMINISTRATION REQUEST

Student's Name _____

Grade _____ Date of Birth _____ Teacher/Homeroom _____

TO BE FILLED OUT BY HEALTHCARE PROVIDER:

Please administer the following medication
to the above-named student as prescribed below:

Medication _____ Dosage _____

Time to be Administered _____

Start Date _____ Stop Date _____

Diagnosis _____

Possible Side Effects _____

If PRN, for signs and symptoms _____

Healthcare Provider Stamp below:

Signature of Healthcare Provider

Date Effective _____

TO BE FILLED OUT BY PARENT/GUARDIAN:

_____ My child is to receive the prescribed medication on "half days".

_____ My child is not to receive the prescribed medication on "half days".

I request that the above medication be administered to my child.

Date _____

Signature of Parent/Guardian

This completed form, along with the medication, must be hand delivered to the school nurse by the parent/guardian. For safety and the prevention of errors, pupils may not carry medication with them during the school day. The medication must be in the original container and labeled by the pharmacy or medical provider if it is a prescription medication.

REQUESTS ARE EFFECTIVE FOR ONE SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY