PISCATAWAY
TOWNSHIP SCHOOLS

Teresa M. Rafferty
Superintendent of Schools

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Piscataway Community Education
1515 Stelton Rd. Rm 103
Piscataway, NJ 08854-1332
732 572-4688
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www.piscatawayschools.org

Dear Parents/Guardians:

The New Jersey Department of Health and Senior Services revised the administrative rule, N.J.A.C. 8:54-4, in 2008, with substantive changes to include the requirement of new vaccines for children attending or entering preschool and licensed child-care centers.

The requirements include:

8:57-4.18 Pneumococcal conjugate vaccine

Every child 12 months through 59 months of age enrolling in or attending a preschool facility or licensed child-care center shall have received at least one dose of pneumococcal conjugate vaccine (PCV).

8:57-4.19 Influenza vaccine

Children six months through 59 months of age attending a preschool facility or licensed child-care center shall annually receive at least one dose of influenza vaccine between September 1 and December 31 of each year.

Documentation of the required vaccines from your healthcare provider must be submitted on or before September 2014 for the Pneumococcal conjugate vaccine and by December 31 of each school year for the Influenza vaccine.

Failure to comply with this requirement is cause for **exclusion from school**.

Thank you for your assistance with this requirement for attendance at school.

Sincerely,

Health Services

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IMMUNIZATION REQUIREMENTS

Age Appropriate Vaccinations for Preschool and Child-Care Centers

4 Doses of DTP or DtaP (one on or after* the 4th birthday)
3 Doses of Polio (one on or after* the 4th birthday)
1 Dose MMR (after 1st birthday)
2 Doses of Measles (on or after 1st birthday)
3 Doses of Hepatitis B if born after 1/1/96
1 Dose of Varicella (on or after 1st birthday)
1 Dose Haemophilus Influenza Type B (HIB) (for children 12 - 59 months of age)
1 Dose Pneumococcal Conjugate (PCV) (for children 12-59 months of age)
1 Dose Influenza Vaccine annually between September 1 and December 31 (for children 6-59 months of age)

New Jersey Department of Health and Senior Services
N.J.A.C. 8:57-4 Chapter 14, Immunization for Pupils in Schools

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PHYSICAL EXAMINATION FORM

Pupil's Name_____ Birthdate_____

School_____ Grade_____

Immunizations: DTP_____ DT_____ Td_____ Tdap_____

Polio_____ Meningococcal_____

MMR_____ MMR_____ HepB_____ HepB_____ HepB_____
Type Type Type

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_____

Family History (if appropriate)_____

Allergy_____

Medication_____

Participation in Physical Education/Sports/Activities_____

Remarks/Impression/Summary_____

Physician's Signature_____

Date of Exam_____ **Physician's Stamp**

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

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/FirstName	Birthdate

Signature of Parent/Guardian_____ Date_____

Any additional information can be attached to this form.

8/13

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Children's Corner Programs

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 **9/13**