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:**

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

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 Doctor.**

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.

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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.

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 Perinatal Cooperative.

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.

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 me:

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 thereof. 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 physician's 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 <u>shall not</u> provide pupils with any medication until all the requirements are met.

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

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TO BE FILLED IN BY SCHOOL NURSE

Prescription # _____ Date _____

Pharmacy _____ Phone _____

Name of Medication _____

Name of Physician _____ Phone _____

Of Tablets Received _____

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PHYSICIAN'S ORDERS

Name of Patient _____

Name of Medication _____

Date of Prescription _____

Dosage _____

Purpose _____

COMMENTS _____

_____

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