Accepted date:_____
Alerts: pages_____

Dr. Charles R. Smith, Jr., ECC
271 Second Street
Palisades Park, New Jersey 07650

SCHOOL HEALTH HISTORY ENTRANCE FORM

TO BE COMPLETED BY PARENT.
Please complete the following and return to the school nurse as soon as possible.

Child's Name_____ Sex M ☐ F ☐ Birth Date _____
(Last) (First)

Grade_____ School _____ Home Address _____

Father's Name _____ Mother's Name_____

Home Phone _____ Work Phone Mother _____ Father_____
Cell Phone: _____ Cell Phone _____

Siblings, Names/Ages_____

Language(s) spoken at home (other than English)_____

II. BIRTH & DEVELOPMENTAL HISTORY

Birth Weight: Pounds _____ ounces

Gestation (Duration of Pregnancy) _____ weeks or _____ months

Pregnancy: Illness of Mother Yes☐ No ☐ If yes, explain: _____

_____

Other areas of concern -- Yes☐ No ☐ If yes, explain: _____

Problems/labor & deliver-- Yes☐ No ☐ If yes, explain: _____

Growth and Development: Age child –

Sat alone _____ Crawled _____ Walked _____ First Spoke _____ Spoke in sentences _____

Coordination (difficulty) Yes☐ No ☐ If yes, explain: _____
(fine motor, large muscle, other areas of concern)

II. FAMILY MEDICAL HISTORY (Please specify: Allergies, Respiratory, Heart, Diabetes, Cancer, Other)

Father_____ Mother _____

Siblings_____ Relative_____

Does your child have health insurance including NJ Family Care/Medicaid, private or other?

Yes____ Company Name:_____ No____

III. HEALTH HISTORY (Please check appropriate column, note year, and explain where applicable.)

Allergy Types	Reaction	School Restriction
Bee/Insect		
Drugs		
Food		
Pollen		
Skin		
Other (i.e. latex)		

Other Conditions	No	Yes	Year(s)	Explain
Asthma/Reactive Airway Passage				
Blood Disorder				
Cancer				
Concussion/Head Trauma				
Diabetes				
Digestive/Feeding Disorder				
Diseases, i.e. chicken pox				
Mononucleosis				
Mumps				
Measles				
Dietary Restrictions				
Emotional Problems				
Genitourinary Problems				
Hearing Difficulty				
Heart Disease (defects)				
Hospitalization(s)				
Severe Infections				
Kidney Disease				
Neuro-muscular Disorders or prosthesis				
Organs missing or impaired function of paired organs; i.e. kidneys, testes, eyes				
Orthopedic Disorder				

Other Conditions	No	Yes	Year(s)	Explain
Central Nervous System Disorder				
Rubella				
Skin Disorder				
Speech Impairment				
Surgical Procedure(s)				
Vision Problems				
Glasses/Contacts				
Other (list and explain) serious illnesses, accident, genetic disorders)				

A. Is the student receiving medication? Yes☐ No ☐ If yes, complete the following:

Medication(s)	Dose	Times	Reason	Date Prescribed	Prescribing Physician

B. Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

Yes☐ No ☐ If yes, explain: _____

_____

_____

C. Does the student require an special procedures and/or treatments?

Yes☐ No ☐ If yes, explain: _____

_____

_____

D. Is the student current under treatment for any health conditions?

Yes☐ No ☐ If yes, complete the following:

Condition Physician Treatment

_____

_____

_____

E. Has the student had a vision screening?

Yes☐ No ☐ If yes, please report results:

_____ (date) _____

F. Has the student had a hearing screening?

Yes☐ No ☐ If yes, please report results:

_____ (date) _____

G. Has the student had any special medical examinations?

Yes☐ No ☐ If yes, complete the following: (i.e., ophthalmologic, neurological, orthopedic, etc.):

Specialty	Physician	Exam Date	Diagnosis	Recommendation

H. Has the student had any experience(s) which you feel may affect his/her physical, mental, and/or social development?

Yes☐ No ☐ If yes, please explain:

_____

_____

_____

_____

I. Please complete: Last medical examination:

Date:	Reason
Physician:	Findings
Address:	
Phone#:	

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

As parent/guardian of the above named student, I hereby allow for the sharing of information between the student's health care team and the nurse, to divulge necessary information to necessary staff.

_____ _____

Date *Signature of Parent/Guardian*

dc/1/2010

UNIVERSAL CHILD HEALTH RECORD

Early Childhood Center - Grade _____ - _____

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name (Last) (First)	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier	Place of Birth

Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note If Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ *I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.*

Name of Health Care Provider (Print)	**Health Care Provider Stamp**
Signature/Date	

Dr. Charles R. Smith, Jr., Early Childhood Center
270 First Street
Palisades Park, New Jersey 07650

State of New Jersey

IMMUNIZATION RECORD

Kindergarten – Grades 12

		Immunization Registry Number	
Name of Child (Last, First, M.I.)		Date of Birth (Mo/Day/Yr)	Sex ☐ Male ☐ Female
Parent/Guardian	Name		
	Address	Telephone No.	

TO BE COMPLETED BY HEALTH CARE PROVIDER

DISEASE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr			
DTaP (DIPHTHERIA, TETANUS, PERTUSSIS) or any combination *If Td or DT, indicate in box*	/ /	/ /	/ /	/ /	/ /			
Tdap (TETANUS, DIPHTHERIA TOXOIDS, ACELLULAR PERTUSSIS)								
IPV (INACTIVATED POLIOVIRUS) OR OPV (ORAL POLIOVIRUS) *If IPV or OPV, indicate in box*	/ /	/ /	/ /	/ /	/ /			
MMR (MEASLES, MUMPS, RUBELLA)								
HEPATITIS B								
VARICELLA								
PCV (PNEUMOCOCCAL CONJUGATE)								
MENINGOCOCCAL								
HPV (HUMAN PAPILLOMAVIRUS)								
HIB (HAEMOPHILUS INFLUENZA TYPE B)								

Lead Screening	
Test Date	Result

Document below single antigen vaccine receipt, serology titers, or varicella disease history		
Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer

☐ Provisional Admission Attached-Date Granted: _____

☐ Medical Exemption Attached

☐ Religious Exemption Attached

VISION EXAMINATION FORM

The Board of Education recommends that all school children have a complete eye examination before entering school in the fall. Good vision is essential to success in school. It is our hope that pre-school eye examinations will help many children to receive the proper vision correction through early detection and/or treatment.

Upon completion of the eye examination, have the examiner indicate his/her findings and recommendations on the form below. This form should be returned to the school nurse.

Student's Name_____ **Date**_____

I have given a complete eye exam with the following diagnosis and recommendations:

		Distance	Near		Distance	Near
Vision Without Correction	O.D.			O.S.		
Vision With Correction						

Muscle Balance _____ Color Test _____

Stereopsis Eye _____

Eye Defects _____

Recommendations/Conclusions

1. Normal Eye Examination Yes ☐ No ☐
2. Corrective lens prescribed Yes ☐ No ☐
3. Re-examine on _____ (Date of Return Visit)
4. Other (Preferential seating, low vision, aides, etc.) _____

_____ _____

Physician's Signature Date

Please Print:

Name of Physician _____

Address _____

Phone Number _____

Dr. Charles R. Smith, Jr., Early Childhood Center
270 First Street
Palisades Park, New Jersey 07650

Diane Nickoloff, B.S.N., R.N., C.S.N.
School Nurse

201-947-2763
201-947-0873 (Fax)

Date

To be filled out by the **family dentist** and **returned to the school nurse.** Thank you

Name of Child_____Grade_____

Date of Birth_____ Telephone number_____

Date of Last Dental Exam_____

Number of Carious Teeth_____

Number of Filled Teeth_____

Number of Missing Teeth_____

Condition of Gums_____

Next Dental Check-up_____

Comments from the Dentist_____

_____

_____
Dentist's Signature

Please Print or Stamp:

Dentist's Name_____
Address:_____