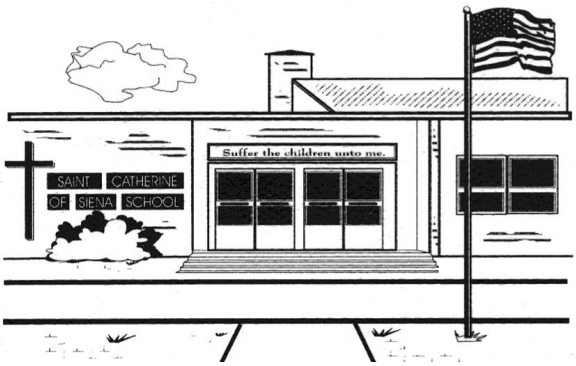

ST. CATHERINE OF SIENA SCHOOL
Middle States Accredited
39 E. Bradford Avenue, Cedar Grove, NJ 07009
Telephone 973-239-6968 • Fax 973-239-1008
www.scs-school-cedargrovenj.org

TO: Parents of NEW Students **Grades 6-8** *and* CURRENT Students **Grade 8 NOT PLAYING SPORTS**
FROM: Mrs. Colleen Kennedy, RN, CSN
RE: Pre-entrance physicals/completed immunizations

In order to enter St. Catherine of Siena School, all NEW students (Grades 6-8) must have **(1) a pre-entrance physical** and **(2) completed immunizations.** In accordance with the recommendation of the NJ Department of Education (N.J. A.C.6A:16-2- 2(d)1), we also recommend that **all current students in grades 8** also receive a physical examination.

For your convenience, I am listing the required immunizations on the back of this letter. **If your child(ren)'s immunizations are incomplete, your child will not be permitted to start school until they are completed.**

Please be sure the health examination form and immunization record are completed and **signed by your physician** with date of examination. ALL forms must be completed, signed and returned by June 1st. **Please remember that your child will not be permitted to enter school if all medical forms are not submitted.** If you have any questions, please feel free to call me at school.

Participating in a sport? If yes, do not use this form. Please use the SPORT Health Forms (*New Jersey Pre-participation questionnaire and physical forms)****. All Students in grades 6-8 who participate in school sponsored sports activities, are required to have yearly physical exams prior to the start of the sports season. All sports questionnaires and physicals must be returned before the first practice of the sport season. All physicals must be done using the New Jersey Pre-participation questionnaire and physical forms.* ***No other physical forms will be accepted.***

ST. CATHERINE OF SIENA SCHOOL *Pre-entrance physicals/completed immunizations*

NJ STATE REQUIREMENTS

DPT	Minimum of 4 doses; one dose must have been administered **on or after the 4th birthday**, or any 5 or more doses. **(NEW)** All students born after Jan. 1, 1997 and enrolled in 6th grade or transferring into a New Jersey school from another state or country must have a booster dose of diphtheria, tetanus and pertussis vaccine.
Oral Polio	Every students less than 7 years of age must have a minimum of 3 doses, provided one dose is given **on or after the 4th birthday**, or any 4 doses, at least 28 days apart.
Measles	Two doses given; first dose must be given **on or after the 1st birthday**. Vaccines are to be separated by no less than one month. (For 2nd dose, laboratory evidence of immunity is accepted.)
Rubella	One dose **on or after the 1st birthday**.
Mumps	One dose **on or after the 1st birthday**.
HIB	All children entering school must provide proof of HIB vaccinations appropriate for the child's age.
Pneumoncoccal	**(NEW)** All students in Pre School must have pneumococcal vaccine series, starting in September 2008.
Hepatitis B	3 doses of Hepatitis vaccine prior to school entrance for first time into Kindergarten or 1st grade.
Varicella	One dose **on or after the 1st birthday** or Physician/Parental history of disease or laboratory evidence of immunity.
Meningococcal	**(NEW)** All children born on or after Jan. 1, 1997 and enrolled in 6th grade or transferring into a New Jersey School from another state or country must have one dose of meningococcal vaccine.
Flu Vaccine	**(NEW)** Children in Pre School on or after Sept. 1, 2008 shall annually receive at least one dose of influenza vaccine between Sept. 1st and Dec. 31st of each year. (Children receiving first time vaccination receive 2 doses spaced 4 weeks apart.)
TB (Mantaux)	Provide the results of your child's most recent Tuberculin Test – if in Category (from country) indicated under NJ Tuberculosis guidelines.

ST. CATHERINE OF SIENA SCHOOL PHYSICAL EXAMINATION

Name _____ ***Exam Date** _____ Age _____ Date of Birth _____
Address _____ City/State/Zip _____ Home Phone _____
School _____ Sport _____ Grade _____ Sex _____
Physician _____ Phone _____ Fax _____
Address _____ City/State/Zip _____

PHYSICIAN OR PROVIDER INFORMATION - PLEASE COMPLETE BOTH PAGES

Height: _____ Weight: _____ Blood pressure: _____/_____ Pulse: _____bpm
Vision: R 20/_____ L 20/_____ Corrected: Y/NContacts: Y/N Glasses: Y/N

	Normal	Abnormal Findings	Comments
Head/Neck			
Eyes/Sclera/Pupils			
Ears/Hearing			
Nose/Mouth/Throat			
Heart: Murmurs/Rhythms			
Lungs: Auscultation/Percussion			
Chest Contour			
Skin			
Abdomen: Assessment(inc. liver, spleen)			
Tanner Stage: Testes/onset of menses			
Hernia	No	Yes/Possible	
Neck/Back/Spine: Range of motion			
Scoliosis			
Upper Extremities			
Lower Extremities			
Neurological: Balance & Coordination:			
Romberg			
Heel Walk			
Tandem Walk			
Nose Touch			
Toe Walk			
Most recent immunization/dates:			
Medications currently in use:			
Allergies:			
Operations or accidents:			

A. Student may participate in athletics: Yes _____ No _____ Date _____
B. Cleared after completing evaluation/rehabilitation for: _____
C. NOT CLEARED FOR: Collision _____ Contact _____ Non-contact _____
Strenuous _____ Moderate _____ Non-strenuous _____
Diagnosis: _____
Recommendations: _____

Examined by: Family Physician/Provider _____ **School Physician _____** **_____MD _____DO _____NP _____PA** **✱Physician/Provider Signature _____**	**Physician's/Provider's Stamp:**

ST. CATHERINE OF SIENA SCHOOL • 39 E. Bradford Avenue, Cedar Grove, NJ 07009 • Tel: 973-239-6968

IMMUNIZATIONS

NAME OF CHILD _____ **DOB** _____ **Sex:** Male ____ Female ____
Last First M.I. Mo/Day/Yr

Parent	Name _____	Telephone #_____
or	Address _____	**Name of Dr.** _____
Guardian	Address _____	**Dr.'s Tel. #**_____

Vaccine Type	DISEASE mo/day/yr	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	mo/day/yr
DIPTHERIA,TETANUS,PERTUSIS (DTP) **(If Td, DtaP, DT*, or TdaP indicate in box)**							
POLIO- ORAL POLIO VACCINE (OPV) **(If Salk Vaccine, indicate IPV in box)**							
MEASLES, MUMPS, RUBELLA (MMR)							
MEASLES					Measles Serology:	Date:	Titer:
RUBELLA					Rubella Serology:	Date:	Titer:
MUMPS					Mumps Serology:	Date:	Titer:
HAEMOPHILUS B (HIB)							
HEPATITIS B							
VARICELLA							
PNEUMOCOCCAL (PCV)							
MENINGOCOCCAL VACCINE							
INFLUENZA VACCINE							

❑ Provisional Admission Attached - Date Granted:	❑ Medical Exemption Attached

MD: _____ **MD Phone:** _____

Address: _____ **Date:** _____

_____

5/2016

ST CATHERINE OF SIENA SCHOOL
New Student Health Survey (To Be Completed by Parent/Guardian)

Student Name: _____ DOB: _____ Grade: _____

Gender: _____ Name of Doctor: _____

Please check if your child has had the following:

Condition	Yes	No	Year	Condition	Yes	No	Year
High blood pressure							
Asthma				TB or contact with TB			
Severe Allergies				Severe or chronic stomach problems			
Frequent or painful urination				West or soils pants			
Concussion				Frequent or severe headaches			
Dizzy or fainting spells				Severe head injury			
Epilepsy				Excessive worry or anxiety			
Depression				Hearing loss			
Speech problems				Eye problems			
Frequent ear infections				Frequent colds			
Wears glasses or contacts				Diabetes			
Scoliosis				Tumor			
Cancer				Serious skin disease			

1. Has your child ever had any serious illnesses or injuries other than those already noted? What? When?
   Explain: _____
   _____
2. List any medications or foods your child is allergic to: _____
3. Has your child been diagnosed with Attention Deficit Disorder? Explain: _____
   _____
   List any medications: _____
4. Had your child had any operations? What? When? Explain: _____
   _____
5. Has your child had any orthopedic (bone or joint) problems? What? When? Explain: _____
   _____
6. Does your child have severe bee sting sensitivity? Local _____ General _____ Explain: _____
   _____
7. Does your child have other health or behavior problems the Nurse should be aware of? Explain: _____
   _____
8. Is your child under regular medical supervision for any of the above conditions? If yes, give name of the physician: _____
9. Please explain any "YES" answers here: _____
   _____
10. Normal pregnancy and delivery? Yes _____ No _____ If No, explain: _____
11. Please contact the School Nurse if you have any questions or concerns.

Parent/Guardian Signature _____ **Date** _____ 5/2016