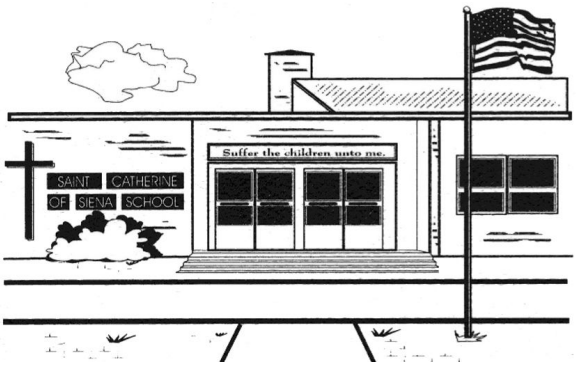

ST. CATHERINE OF SIENA SCHOOL
Middle States Accredited
39 E. Bradford Avenue, Cedar Grove, NJ 07009
Telephone 973-239-6968 • Fax 973-239-1008
www.scs-school-cedargrovenj.org

TO: New Parents/Students PK3 & PK4
FROM: Mrs. Bethanie Sundlin, RN, BSN
RE: Pre-entrance physicals/completed immunizations

In order to enter St. Catherine of Siena Pre School Program, all new students are required to have:

1) Pre-entrance physical exam
2) Completed updated immunizations
3) New Student Health Survey
4) Authorization for Exchange
5) Food Allergy Forms

Physical examination forms and immunization records must be completed and signed by your physician with the date of examination.

All forms must be completed, signed and returned by June 1st.

Please remember – your child will not be permitted to enter school if all medical forms and completed immunizations are not submitted.

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 • 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

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

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

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	

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