ALLENDALE PUBLIC SCHOOLS
ALLENDALE, NJ
KINDERGARTEN HEALTH FORMS

Dear Parent:

Welcome to the Allendale Public Schools.

In accordance with N.J. Board of Education code, the following requirements must be met in order for your child to enter Kindergarten.

1. **Health History Questionnaire – to be completed by parents.**
2. **Physical Exam – only examinations done after January 1, 2012 will be accepted (form attached).**
3. **Up to date Immunization history, including:**

    a) **D.P.T. Vaccine – minimum of 4 doses - *one given after 4th birthday.**

    b) **Polio Vaccine – minimum of 3 doses - *one given after 4th birthday, or any appropriately spaced combination of 4 doses.**

    c) **Measles – Mumps – Rubella – minimum of 2 doses (started after 1st birthday).**

    d) **Varicella Vaccine – or written statement of having a history of the disease (started after 1st birthday).**

    e) **Hepatitis B Vaccine – minimum 3 doses appropriately spaced.**

    f) **Students born in or transferring from certain countries may require TB testing.**

4. **Kindergarten Vision and Hearing form.**

Please submit all of the above to the Hillside School Health Office by **May 1st** of the registration year.
Thank you for your cooperation

Karen De Pol, RN
Hillside School Health Office

ALLENDALE PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES
ALLENDALE, NJ 07401

Health History Questionnaire to be completed in entirety by parent/guardian

Student Name:______________________________ Entering Grade Level ____________

Does your child have any of the following medical conditions?

	Yes	No		Yes	No
Asthma	___	___	Orthopedic Problems	___	___
Diabetes	___	___	Cardiac Problems	___	___
Frequent Headaches	___	___	Neurological Disorder	___	___
Hearing Problems	___	___	Seizure Disorder	___	___
Lyme Disease	___	___	Vision Problems	___	___
Blood Disorders	___	___	Eyeglasses/contacts	___	___

Other___________________________

If you have checked any of the above, please schedule an appointment with the school nurse.

My child can use the bathroom and can clean themselves? __ Independently __ With help
My child can wash hands independently? Yes ___ No ___

Does your child have any FOOD allergies? Yes ___ No ___
If yes, list and describe the allergic reaction: ____

Does your child have allergies to insect stings, pollen,other? Yes ___ No ___
If yes, list and describe the allergic reaction: ____

Does your child have any allergies to medications? Yes ___ No ___
If yes, list the medication(s) and describe the allergic reaction______________________________

Does your child take any medication on a regular basis? Yes ___No___
If yes, list the medications(s)____

Has your child had any serious illness, accidents or surgeries? If yes please describe and give dates:
____

Are there any other physical or emotional conditions that might bear on this child's ability or performance?
____

As the parent/guardian of the above named student, I hereby authorize the release of pertinent medical information to the appropriate faculty and staff involved in the care of my child.

____

Parent/Guardian Signature **Date**

ALLENDALE PUBLIC SCHOOLS

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

UNIVERSAL CHILD HEALTH RECORD *New Jersey Department of Health and Senior Services*

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last) (First)*	Gender Male Female	Date 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.

Parent Signature	Date

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

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

Abnormalities Noted:		
	Weight	
	Height	
	Blood Pressure	

IMMUNIZATIONS

- ☐ Immunization Record Attached
- ☐ Date Next Immunization Due:

☐ Provisional Admission Attached – Date Granted:______ Medical Exemption Attached______ Religious Exemption Attached______

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	Results
Hgb/Hct			**Hearing**		Right Left
Lead: Capillary Venous			**Vision**		Right Left
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	

Student: ______________________ Date of Birth: ______________

IMMUNIZATION HISTORY

Please print clearly or attach a separate Immunization Report

Vaccine Type	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, PERTUSSIS *(If Td or DT, indicate in box)	/ /	/ /	/ /	/ /	/ /	/ /
POLIO-INACTIVATED POLIO (If oral vaccine, indicate OPV in box)	/ /	/ /	/ /	/ /	/ /	/ /
MEASLES, MUMPS, RUBELLA (MMR)	/ /	/ /	/ /	History of Disease or Titer		
MEASLES	/ /	/ /	/ /			
RUBELLA	/ /	/ /	/ /			
MUMPS	/ /	/ /	/ /	Hepatitis B	Date:	Titer:
HAEMOPHILUS B (HIB)**	/ /	/ /	/ /	Varicella	Date:	Titer:
HEPATITIS B	/ /	/ /	/ /	Measles	Date:	Titer:
VARICELLA	/ /	/ /	/ /	Mumps	Date:	Titer:
PNEUMOCOCCAL CONJUGATE**	/ /	/ /	/ /	Rubella	Date:	Titer:
MENINGOCOCCAL	/ /	/ /	/ /	/ /		
HEPATITIS A***	/ /	/ /	/ /	/ /		
HPV*** (HUMAN PAPILLOMAVIRUS)	/ /	/ /	/ /	/ /		
OTHER	/ /	/ /	/ /	/ /		

*REQUIRES MEDICAL EXEMPTION

**REQUIRED FOR DAY/CHILD CARE ENROLLEES (2 months-5th birthday only)

***NOT REQUIRED

Physician (Print or Stamp)

Physician Signature

(OVER)

ALLENDALE PUBLIC SCHOOLS
Hillside School Health Services
Vision and Hearing Form

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

Upon completion of the vision and hearing examinations, please have the examiner indicate his/her finding and recommendations on the form below. This form should be returned to the school nurse before the start of school.

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	O.D.	______	______	O.S	______	______

Muscle Balance: ____________________________ Color Test: ____________
Stereopsis: ________________________________ Eye Defects: ____________

Fingings:

1. Normal eye examination ______________
2. Corrective lens prescribed: Yes___ No ___
3. Re-examine in ____________________________
4. Other___________________________________

Date of Exam: ____________ Signature:__________________________________
Office Stamp:

HEARING EXAMINATION

Hearing: Right Ear ____________________ Left Ear________________________

Ears – examination of canals and drums: ______________________________________

Findings:____

____

Date of Exam:____________ Signature:________________________
Office Stamp: