

OUR LADY OF VICTORIES
 36 Main Street
 Sayreville, NJ 08872
 (732) 254-1676
SCHOOL HEALTH REGISTRATION

Name of Student _____ Date of Birth _____

Dear Parent or Guardian,

Your child **MUST** meet the following NJ State Health Requirements by September to enter:

1. All immunizations must be up-to-date.
2. Physical exam-attached form to be completed by child's physician-Page 4.
3. Please return pages 1, 2 & 3 now, with pages 4 and 5 (medical & dental) to be completed & returned. (*Dental applies to Kindergarten entry only!)

A. IMMUNIZATIONS

Vaccine Type	Primary	Series	Doses	Boos	ter	Doses
	1st	2nd	3rd	1 st -18mos	4 years	10 years
DPT / Td / Tdap						
IPV (Polio)						
MMR						
Measles (Live Vaccine/Disease)						
Rubella (Vaccine Only)						
Mumps (Live Vaccine/Disease)						
HIB Vaccine					Meningo-coccal	
Hepatitis B Vaccine				Varivax		
Prevnar						
Flu Vaccine				Hep. A (Optional)		

B. HEALTH HISTORY

A. Family History

1. General Health (Both parents): _____
2. Significant Family Problems: _____

B. Childhood Illnesses, Infections, or Injuries: (CIRCLE)

Frequent nosebleeds	Strep infections	Visual problems	Hives
Frequent earaches	Frequent colds	Hearing problems	Eczema
Frequent sore throats	High fevers	Congenital defects	Headaches
Fractures	Hyperactivity	Other _____	

ALLERGIES: _____

OUR LADY OF VICTORIES

36 Main Street
Sayreville, NJ 08872
(732) 254-1676

HEALTH HISTORY (Continued)

C. Please check if child has had the following & give dates:

- | | |
|----------------------|--------------------------|
| Asthma _____ | Mononucleosis _____ |
| Bronchitis _____ | Mumps _____ |
| Chicken Pox _____ | Pneumonia _____ |
| Diabetes _____ | Rheumatic Fever _____ |
| German Measles _____ | Seizure Disorder _____ |
| Heart Disease _____ | Surgery _____ |
| Hepatitis _____ | Urinary Infections _____ |
| Measles _____ | |

D. Hospitalizations _____

E. Is your child taking medication on a regular basis? NO _____ YES _____
PRESCRIPTION _____ or OVER-THE-COUNTER _____
If Yes: Daily Dose & Condition taken for _____

- F. Feeding & Digestion
1. Appetite good? _____
 2. Please list any foods that may disagree with him/her: _____
 3. Frequent diarrhea or constipation? _____
 4. Frequent stomach aches? _____

- G. Behavioral or Developmental Habits
1. Does child exhibit any of the following : (Please circle)
 Thumb sucking Nail biting Bed wetting Nightmares
 Breath holding Fearful Reluctance to leave parent
 Wetting pants: Occasionally _____ Frequently _____
 2. Child's Developmental History:
 - a. Age at which child walked _____
 - b. Age at which child talked _____

H. Is there any other information which would be helpful in understanding your child better, thus enabling her/him to benefit more fully from school experience?

(Parent's Signature)

(Date)

OUR LADY OF VICTORIES
 36 Main Street
 Sayreville, NJ 08872
 (732) 254-1676
 TO BE COMPLETED BY STUDENT'S
 PHYSICIAN

_____ (Name of Student) _____ (Date of Exam)

Height _____ Weight _____ Blood Pressure & Pulse _____

Hearing Acuity: R _____ L _____

Visual Acuity: R _____ L _____ Glasses: Yes _____ No _____

Color: _____ Muscle Balance: _____ Allergies: _____

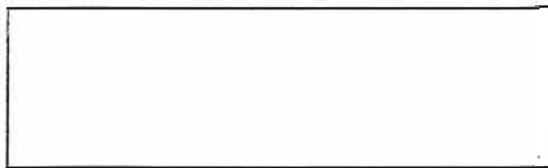
Please check items below where abnormalities are known or found and describe in space provided:

Skin _____	Glands _____	Nose/Throat _____
Eyes _____	Heart _____	Mouth _____
Ears _____	Lungs _____	Speech _____
Extremities _____	Abdomen _____	Genito-Urinary _____
Scoliosis _____	Hernia _____	Nutritional Status _____

Description: _____

Treatment advised: _____

Medical recommendations for academic/activity participation: _____



MD Stamp

 (Physician's Signature) MD

 (Address)

 (Date)

Items checked are needed according to current School Nurse Records:

Immunization Records _____	MMR# _____	DPT _____	IPV _____
Varivax _____	Hib _____	Prevnar _____	Hep B _____
Meningococcal _____	Tdap _____	Physical Exam _____ (Within 6 mos)	Influenza Vaccine _____

OUR LADY OF VICTORIES

36 Main Street
Sayreville, NJ 08872
(732) 254-1676

The school health policy recommends an annual dental examination by your family dentist for each child.

Please have the attached form completed by your dentist and return it to the school nurse as soon as possible following your child's dental examination . If your child has had an examination within the past six (6) months, then please have your dentist simply complete the form and return it.

Please call me if there is any reason why your child cannot have a dental examination completed. Thank you.

Sincerely,
Sharyn Ross, RN
School Nurse

DENTAL EXAMINATION REPORT

I have examined _____ Grade _____ on _____
(Date)

- _____ 1. Prophylactic visit: There is no need for corrective work at this time.
- _____ 2. Treatment has been completed.
- _____ 3. There is need for dental care at this time. An appointment has been scheduled:

YES _____ NO _____

(Dentist's Signature) DDS

(Address)