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	1st-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:_____

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HEALTH HISTORY (Continued)

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

____Asthma_____
____Bronchitis_____
____Chicken Pox_____
____Diabetes_____
____German Measles_____
____Heart Disease_____
____Hepatitis_____
____Measles_____
____Mononucleosis_____
____Mumps_____
____Pneumonia_____
____Rheumatic Fever_____
____Seizure Disorder_____
____Surgery_____
____Urinary Infections_____

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)

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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

_____MD
(Physician's Signature)

_____
(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_____

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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_____

_____DDS
(Dentist's Signature)

_____
(Address)