ALLENDALE PUBLIC SCHOOLS
ALLENDALE, NJ

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, 2016 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 1, 2016.**
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 by Parent/Guardian

Student Name: _____ **DOB** _____

Does your child have any of the following medical conditions?

	Yes	No		Yes	No
Asthma	___	___	Orthopedic Problems	___	___
Diabetes	___	___	Cardiac Problems	___	___
Frequent Headaches	___	___	Seizure Disorder	___	___
Hearing Problem	___	___	Vision Problems	___	___
Lyme Disease	___	___	Glasses/	___	___
Blood Disorders	___	___			

Does your child have any allergies? (foods, insect stings, other) Yes____ No___
If yes, list and describe the allergic reaction: _____

_____

Does your child have any allergies to medication(s)? Yes___ No___
If yes, list the medication(s) and describe the allergic reaction:_____

_____

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

_____

_____

Are there any other physical or emotional conditions that might bear on this child's abilities 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

12/14

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:

1/09

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

CH-14 SEP 08 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

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
SCHOOL HEALTH SERVICES
100 BROOKSIDE AVENUE
ALLENDALE, NJ 07401

Karen De Pol, RN
Hillside School Nurse
201-327-2020 ext. 3244

Patricia Bombolevicz RN
Brookside School Nurses
201 327-2021, ext. 2231

GUIDELINES FOR ADMINISTRATION OF MEDICATION AT SCHOOL

1. **The parent or guardian provides a written request for the administration of the prescribed medication at school.**
2. **Prescribed over-the-counter medications must be accompanied by written physician's orders that provide the school with the child's name, diagnosis, name of the drug, dosage, time of administration, and side effects when necessary.**
3. **Medication is to be brought to school in the original container, appropriately labeled by the pharmacy or physician.**
4. **The school nurse or parent/guardian is the only one permitted to administer medication in the school.**
5. **Records of giving medication during school hours will be maintained by the school nurse.**

It is recommended that if your child has a special condition such as food allergies, asthma, etc, medications will be kept in school for emergency situations. It is suggested that such medications be brought to school at the beginning of the school year and the previously stated guidelines be followed.

Your cooperation in abiding by this policy is necessary for maintaining the health and safety of all of the children in the school.