Elementary Schools

Township of Union Public Schools

2369 Morris Ave, Union, NJ 07083

New Student Registration Medical Packet

If you are registering a new student you must provide the following:

1. **Immunization record**: proof of required immunizations in the form of a school record, or a public health record. The record must be legible and translated into English.

2. **Physical Exam:** All students must submit a physical examination within 30 days of their start date. A physical examination form is included in this packet.

3. **Mantoux Test:** If the student is entering from outside of the United States, they may need proof of a Mantoux test done within the past six months. The school nurse will make you aware.

4. Health History: Please fill out both pages of the attached health history

For information regarding free or reduced fee health information please go to:

www.njfamilycare.org

www.findahealthcenter.hrsa.gov

TOWNSHIP OF UNION PUBLIC SCHOOLS

Linda M. Ionta, Director
Athletics, Health, Physical Education & Nurses

NEW JERSEY DEPARTMENT OF EDUCATION - IMMUNIZATION GUIDELINES

DTP (Diphtheria, Tetanus, Toxoid and Pertussis

- Ages 1-6 years - 4 doses with 1 does given *on/or* after the 4th birthday, or any 5 doses
- Ages 7 or Older - 3 doses of TD or a combination of DTP, DtaP, and Td

Tdap Booster

- Students born *on/or* after 1/1/97 attending or transferring into New Jersey school at Grades 6 or higher.

Poliovirus Vaccine

- Ages 1-6 years - 3 doses with one dose given on/or after the 4th birthday, or any 4 doses
- Ages 7-17 years - 3 doses either OPV or IPV separately or in combination

Measles

- 2 doses of measles containing vaccine.
- 1st dose given *on/or* after the 1st birthday (If before 1st birthday, re-immunization is required.)
- Intervals between 1st and 2nd measles/MMR cannot be less than 1 month. Laboratory evidence of immunity is also acceptable.

Rubella

- 1 dose or laboratory evidence of immunity. First dose given *on/or* after the 1st birthday. (If before 1st birthday, re-immunization is required.)

Mumps

- 1 dose or laboratory evidence of immunity. First dose given *on/or* after the 1st birthday. (If before 1st birthday, re-immunization is required.)

Hepatitis B Virus Vaccine

- Ages 1-15 - 3 doses or 2 doses Adult formulation (ages 11-15) or laboratory evidence of immunity.

Varicella (Chicken Pox) Vaccine

- 1 dose given *on/or* after 1st birthday or documented proof of disease by a parent/guardian or physician statement or laboratory evidence of immunity.

Meningococcal Vaccine

- Grades 6-12 - Students born *on/or* after 1/1/97 attending or transferring into New Jersey school at grade 6 or higher.

Mantoux Test (PPD)

- Students entering a United States school for the 1st time in New Jersey or transferring into a New Jersey school ***from any country not listed below must receive*** an IGRA or Mantoux Tuberculin Skin Test:

Antigua
Australia
Austria
Barbados
Barbuda
Belgium
Bermuda
Canada
Cayman Islands
Cuba
Cyprus
Czech Republic
Denmark
Finland
France
Germany
Greenland
Grenada
Iceland
Ireland
Israel
Italy
Jamaica
Jordan
Lebanon
Luxembourg
Malta
Monaco
Montserrat
Netherlands
Netherlands Antilles
New Zealand
Norway
Oman
Puerto Rico
Saint Kitts and Nevis
San Marino
Sweden
Switzerland
Trinidad
Tobago
United Kingdom of Great Britain and Northern Ireland
United States of America
United Virgin Islands

UNION TOWNSHIP PUBLIC SCHOOLS
UNION, NEW JERSEY 07083

STUDENT HEALTH HISTORY

Student's Name: _____

Date of Birth: _____

Birthplace: _____

Where did the student reside before entering this school? _____
(city/state)

_____
(country)

	YES	NO
Is this the first time this student will attend school in the United States?	____	____
Has anyone in student's close family ever had		
Diabetes (high sugar in blood) ?	____	____
Allergies (hay fever or asthma)?	____	____
Migraine headaches?	____	____
Heart trouble?	____	____
High blood pressure?	____	____
Sudden death?	____	____
Has student had or does student have		
Tendency to lose consciousness (faint) ?	____	____
Convulsions or epilepsy?	____	____
Heart trouble?	____	____
High blood pressure?	____	____
Persistent cough?	____	____
Chest pain with exercise?	____	____
Dizziness or faintness with exercise?	____	____
Has student had or does student have		
Very bad (impaired) vision in one eye?	____	____
Temporary loss of vision?	____	____
To wear glasses or contact lenses?	____	____

	YES	NO
Has student had or does student have		
Hearing loss?	____	____
Perforated ear drum?	____	____
Sinus infection?	____	____
Broken nose?	____	____
Orthodontia (teeth straightened)?	____	____
Has student had or does student have		
Kidney problems?	____	____
(Boys) Loss of function or absence of testicles?	____	____
(Girls) Menstrual problems?	____	____
Age of onset of menstruation_____		
Has student had or does student have		
Asthma (wheezing)?	____	____
Hay fever?	____	____
Hives or rash?	____	____
Bee sting reactions (allergy)?	____	____
Reaction to medicine (allergy)?	____	____
Has student or does student		
Smoke?		
Take any medicine regularly?	____	____
If yes, name_____		
Take medicine for emergency use?	____	____
If yes, name_____		
Has student or does student have any injury?	____	____
Has student had or does student have		
Tendency to bleed or bruise easily?	____	____
Anemia ("tired" blood)?	____	____
Weight problem (under or overweight)?	____	____
Has student had or does student have a skin condition?	____	____
If yes, name_____		
Has student ever been told to give up sports because of health problems?	____	____

Additional information concerning "YES" checked above:_____

_____

Parent/Guardian Signature: _____ Date: _____

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	

Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.