FY-12

STATE OF NEW JERSEY
HEALTH HISTORY AND APPRAISAL

IMMUNIZATION REGISTRY NUMBER

Name of Child (Last, First, M.I.) | Date of Birth (Mo/Day/Yr) | Sex ☐ Male ☐ Female

PARENT OR GUARDIAN — NAME | TELEPHONE NO.

ADDRESS

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
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination *(If Td or DT, indicate in corner box)*					
Tdap					
POLIO – INACTIVATED POLIO VACCINE (IPV) *If oral vaccine, indicate (OPV) in corner box*					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB)**					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE **					
MENINGOCOCCAL					
HEPATITIS A ***					
HPV (HUMAN PAPILLOMAVIRUS) ***					
OTHER					

LEAD SCREENING	
Test Date	Result

Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

☐ Provisional admission attached–Date Granted: _____ ☐ Medical exemption attached ☐ Religious exemption attached

HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR
FOOD ALLERGIES		DIABETES		LYME DISEASE		JUVENILE RHEUMATOID ARTHRITIS	
NON-FOOD/NON-DRUG ALLERGIES		INFLUENZA (FLU)		MONONUCLEOSIS		AUTISM SPECTRUM DISORDERS	
		OTHER		NEUROMUSC. DISORDER		HEMATOLOGICAL DISORDERS	
ASTHMA		DRUG ALLERGIES		CHRONIC OTITIS MEDIA		ADD/ADHD	
CONGENITAL DISORDER		HEART DISEASE		AUTO IMMUNE DISORDERS			
CONVULSIVE DISORDER		HEPATITIS		STREP INFECTIONS			

HEALTH SCREENING CODE: N = Normal; R = Referred; T = Under Treatment; C = See Comments

Grade/Age																
Date																
Height																
Weight																
BMI																
Blood Pressure																
VISION With correction	R															
	L															
	BOTH															
VISION Without correction	R															
	L															
	BOTH															
Muscle Balance																
Color Perception	Date															
	Results															
HEARING Date																
HEARING Sweep Check	R															
	L															

BIENNIAL SCOLIOSIS SCREENING (Beginning at Age 10) — Date _____ Date _____ Date _____ Date _____ Date _____

Referred for abnormal result ☐ ☐ ☐ ☐ ☐

TB Screening (Mantoux Test)	Date	Date
Tested		
Read		
Result (MM)		

Chest X-Ray	Date	Result: Normal	Result: Abnormal

Medication
Reactor No Rx ☐
Date Started _____
Date Completed _____

**REQUIRED FOR DAY/CHILD CARE ENROLLEES (2 Months-5th Birthday Only) ***Not Required

PHYSICAL EXAMINATIONS

Date	Grade/Age	Type of Exam	Significant Findings	Medical Provider

Date	RECORD: Findings and Recommendations of Physicians including medications, operations and injuries; Modification of School Program; Referrals and Follow-up; Conference with Parents, Teachers; Counseling with Student. Individual Nurses notes must be attached.	SIGNATURE