FREEHOLD TOWNSHIP ELEMENTARY/MIDDLE SCHOOLS
HEALTH REQUIREMENTS FOR STUDENTS TRANSFERRING IN

I. IMMUNIZATION

A. Proof of immunization must be submitted upon transfer from a school within New Jersey or within 30 days if from outside the state.

B. Proof shall consist of an official school record or a record signed by a licensed physician or advanced practice nurse.

	IMMUNIZATION REQUIREMENTS (AGE <6) Kindergarten /Grade 1	**IMMUNIZATION REQUIREMENTS (Age 7 or older)**
DTaP	4 doses, with one dose on or after 4th birthday OR any 5 doses	3 doses of Td or a combination of DTP, DTaP and TD to equal 3 doses . If born on or after January 1, 1997 shall have received 1 dose of Tdap , provided at least 5 years since last documented tetanus dose and entering grade 6 or from out of state or country
Polio	3 doses, with one dose given on or after 4th birthday, OR any 4 doses	3 doses
Measles	2 doses (first dose on or after 1st birthday) of a measles containing vaccine, if born after 1/1/90 laboratory evidence of immunity	1 dose, if born before 1/1/90 (on or after 1st birthday) 2 doses , if born on or after 1/1/90 OR laboratory evidence of immunity
Rubella Mumps	1 dose Rubella and 1 dose mumps vaccine (on or after 1st birthday) OR laboratory evidence of immunity	1 dose Rubella and 1 dose mumps vaccine OR laboratory evidence of immunity
Varicella	1 dose on or after first birthday OR laboratory evidence of immunity OR physician history of disease	1 dose on or after first birthday OR laboratory evidence OR physician history of disease
Meningococcal		1 dose, if born on or after January 1, 1997 and entering grade 6 or above
Hepatitis B	3 doses OR laboratory evidence of immunity	3 doses OR laboratory evidence of immunity (2 dose Adult formulation acceptable if doses given between 11-15 years of age)

II. TUBERCULOSIS TESTING

A Mantoux TB skin test or interferon gamma release assay blood test for tuberculosis must be given to any student who transfers in from another country designated as high risk by the Department of Health. You can have the Mantoux test at no charge at the Monmouth County Tuberculosis Clinic, 3435 Highway 9 North, Freehold, NJ 07728. Please call 732 308-3750 for further information. **Contact your school nurse to determine if tuberculosis testing is required for your child.**

III. PHYSICAL EXAMINATION

A. New Jersey Administrative Code 6A:16-2.2 requires an entrance physical examination upon enrollment into school. Parents are to provide this examination documentation

1. If transferring from a New Jersey school, the sending school district shall ensure that documentation of the entry examination is fowarded to the receiving school district as per NJAC 6A:16-2.4 (d).
2. If transferring into a New Jersey school from out of state or out of country, the entry physical exam documentation shall be submitted within 60 days of entry.

B. It is also recommended that subsequent medical examinations of the student occur at least once during each developmental stage, early childhood, pre-adolescence and adolescence.

_____

DATE OF TRANSFER

N129/10

FREEHOLD TOWNSHIP SCHOOLS
STUDENT HEALTH HISTORY AND RECORD STATUS

Student_____Date of Birth_____Place of Birth_____
Address_____Phone_____Cell Phone_____
Name/Address of Previous School_____
Grade_____Male ☐ Female ☐
Parents/Guardians Name_____
Student lives with_____
Custody/Visitation Restrictions Yes No (Court papers must be supplied if applicable)
Do you want information on NJ Family Care/Health Care Coverage for Uninsured Children? Yes No

PRENATAL AND DEVELOPMENTAL HISTORY

List any problems during pregnancy or newborn period_____
_____
Has your child been hospitalized for any reason since birth?
_____ List any developmental
delays_____
_____

FAMILY HISTORY

This child is #_____of _____ children. Recent changes in family life_____
_____
Are there any problems which might affect your child's learning? _____

Does any close relative in your family have a history of: (check and indicate relationship to this child)
Diabetes_____ Cancer_____ High Blood Pressure_____Heart Disease_____
Seizure Disorder_____ Blood disorders_____Mental Illness_____
Arthritis_____Other_____

MEDICAL HISTORY

Please indicate yes/no and explain the type of care needed for any yes response:
Yes No Allergies_____ Yes No Diabetes_____
Yes No Heart Disease_____ Yes No Asthma_____
Yes No Lyme Disease_____ Yes No Ear Infections_____
Yes No Strep Infections_____Yes No Seizure/Convulsions_____
Yes No Hearing problems_____ Yes No Vision Problems_____
Yes No Neurological Problems_____Yes No Surgery_____
Does your child take any medication? Yes No Name of Medication_____
Does your child have any other health issues?_____
_____

HEALTH INFORMATION WILL BE SHARED WITH SCHOOL PERSONNEL ON A "NEED TO KNOW" BASIS

_____ _____
DATE **SIGNATURE OF PARENT/GUARDIAN**

For School Nurse's Use:
Immunizations complete_____Physical Exam_____ Mantoux_____ Health Record Received_____

FREEHOLD TOWNSHIP SCHOOLS

PHYSICAL EXAMINATION

Student_____Birthdate_____ Date of exam_____ (within 1 year of entry)

ALL ITEMS MUST BE COMPLETED: Height_____Weight_____

Vision_____Hearing_____Blood Pressure_____

HEALTH HISTORY (INCLUDE PRENATAL, BIRTH AND DEVELOPMENTAL HISTORY)

DISEASE HISTORY (please specify type and age of onset):

Allergies_____ Convulsive Disorders_____

Congenital Defects_____ Diabetes_____

Drug Sensitivities_____ Heart Disease_____

Hepatitis_____ Otitis Media_____

Neuromuscular Disorders_____ Rheumatic Fever_____

Asthma_____ Strep Infections_____

Chickenpox_____ Mononucleosis_____

Lyme Disease_____ Other Illnesses_____

Operations or Injuries_____

PHYSICAL EXAMINATION: (Circle Yes= Normal No= report on comments)

Head/Neck	**YES**	**NO**	**Abdomen assessment(liver, spleen)**	**YES**	**NO**
Eyes/Sclera/Pupils	**YES**	**NO**	**Neck, Back, Spine ROM**	**YES**	**NO**
Ears	**YES**	**NO**	**Upper extremities**	**YES**	**NO**
Nose/Mouth/Throat	**YES**	**NO**	**Lower Extremities**	**YES**	**NO**
Heart/Murmur/Rhythm	**YES**	**NO**	**Neurological (balance, coordination)**	**YES**	**NO**
Lungs	**YES**	**NO**	**Tanner Stage (testes/menses)**	**YES**	**NO**
Chest Contour	**YES**	**NO**	**Absence of scoliosis**	**YES**	**NO**
Skin	**YES**	**NO**	**Absence of hernia**	**YES**	**NO**

Abnormal Findings/Comments_____

_____

MEDICATIONS CURRENTLY BEING USED_____

RECOMMENDATIONS OR RESTRICTIONS:

IMMUNIZATION RECORD (EXACT DATES--MONTH/DAY/YEAR-PHYSICIAN MAY ATTACH A SIGNED/STAMPED COPY OF IMMUNIZATION RECORD AS REQUIRED BY LAW)

	#1	**#2**	**#3**	**#4 (on/after 4th birthday)**	**#5**
DTaP	_____	_____	_____	_____	_____
POLIO	_____	_____	_____	_____	

RUBELLA VACCINE* (given after 1st birthday) _____ - OR- **#1 MMR**_____

MUMPS VACCINE* (given after 1st birthday) _____ **#2 MMR*_____**

MEASLES VACCINE *(given after 1st birthday)_____

HEPATITIS B VACCINE* #1_____ **#2**_____ **#3**_____

VARICELLA VACCINE* (after 1st birthday) _____**OR DISEASE DATE**_____

MENINGOCOCCAL (if born on or after 1/1/97 and entering Grade 6 or from out of state or country) _____

*Or laboratory evidence of immunity is also acceptable

LEAD TEST DATE AND LEVEL (optional) _____ Mantoux_____(on or after 4th birthday if born out of country)

I have examined this child and find him/her physically fit to participate in all school activities.

SIGNATURE OF PHYSICIAN_____

(Counter-signatures are not acceptable)

PHYSICIAN STAMP

N120/09New Student Exam