MENDHAM TOWNSHIP ELEMENTARY SCHOOL
Every Student Every Day

Dear Parents:

Welcome to Mendham Township Elementary School. We are now accepting registrations for the 2020-2021 school year. Spaces are limited, and enrollment is on a first-come first serve basis. Prospective Pre-Kindergarten students must be 3 or 4 years old by September 1, 2020. **All students entering the Pre-School program must be toilet trained in order to enroll.**

All of our registration forms can be accessed on our website www.mendhamtwp.org . These forms include:

- **Child's original birth certificate**
- ****Child's immunization records (Record from Doctor).**
- **Proof of residency – current utility bill**
- **Notarized homeowner/renter certificate of residency**
- **Registration/Transportation Form**

By N.J. Law, we will admit no child on the first day of school without all immunization requirements.

***ALL PRE-SCHOOL STUDENTS MUST HAVE A RECENT AND UP TO DATE PHYSICAL*

In order for children to enter school in August 2020, they must have had the following immunizations (Chapter 14, NJ Sanitary Code):

- Pre-K children 6 months through 59 months are required to receive about one dose of influenza vaccine between September 1st and December 31st of each year.
- Diphtheria, pertussis, tetanus immunization: a minimum of four doses, one dose must be **after** the fourth birthday (DPT).
- Poliovirus vaccine: a minimum of three dose of live, trivalent, or oral Poliovirus vaccine, one dose must be **after** the fourth birthday,
- Rubella (regular measles): First vaccine must be given **after** the first birthday, or have a medical documentation of the history of the disease.
  Proof of a second measles vaccine is required (this is most often given as an MMR) no less than 30 days after the first dose.
- Rubella (German measles) vaccine, one required (usually an MMR).
- Mumps: one required (usually an MMR).
- Hepatitis B vaccine. Series of three required.
- Varicella (chicken pox). Required as of September 2004 or documentation of disease.
- A record of any other immunization or TB test that your child may have had.

Sincerely,
Ms, Julianne Kotcho, Principal

1/9/20 co

PRE-SCHOOL

MENDHAM TOWNSHIP SCHOOLS

PRE-KINDERGARTEN PHYSICAL EXAMINATION/IMMUNIZATION RECORD

Child's name (last)_____**(first)**_____**B.D.**_____**Sex**_____

Height_____**Weight**_____**Date Of Examination**_____

CHECK IF THERE IS A PROBLEM/ABNORMALITY

Nose_____ Spine_____Lungs

Throat_____ Chest_____ Gums/teeth_____

Abdomen_____ Genitals_____ Glands_____

Feet_____ Skin_____ Nutrition_____

Blood pressure_____Heart_____ _____

Healthy child? Yes_____ No _____

Allergies _____

Required Daily Medications_____

Special Problems/Physical Restrictions_____

Student may participate fully in all school programs including Physical Ed._____

Vision	Glasses
near_____	yes_____
far_____	no_____

Hearing

right_____

left _____

IMMUNIZATIONS	DATES	IMMUNIZATIONS	DATES
*DPT 1	_____	POLIO—(OPV) OR(IPV)	
*DPT 2	_____	(TYPE)	
*DPT 3	_____	*1_____	_____
*DPT/DTaP 4	_____	*2_____	_____
*DTP/DTaP 5 (on or after 4th birthday)	_____	*3_____	_____
		*4_____ (On or after 4th birthday)	_____
MMR# 1 *(on or after first birthday)	_____	* HIB _____2_____3_____	
MMR# 2 *(on or after fourth birthday)	_____	4_____5_____	
*Varicella #1_____#2_____			
Tuberculin Test: (Type) Mantoux____Tine____ (result) _____	_____	* HBV #1_____#2_____ #3_____	
Meningococcal ____ ____ ____ ____ ____ ____ ____ ____		Pneumococcal _____ _____ _____ _____ _____ _____	
Hepatitis A _____ _____			

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Physicians signature

***Required by NJ State Law to enter Kindergarten**

See school nurse for medical or religious exemptions

NAME: _____ *(To be filled out by parent)*

CHILD'S HEALTH HISTORY

PRENATAL AND BIRTH HISTORY

*Problems during pregnancy*_____ *Full term?*_____
*Length of labor*_____ *Type of delivery: normal, forceps, caesarean*
*Condition at birth: normal*_____*jaundiced* _____, *cyanotic*_____
*Birth weight*_____

DEVELOPMENTAL HISTORY: *Please record any developmental problems (i.e. delayed speech, poor coordination)*

_____

_____

MEDICAL HISTORY: *Please check and include dates if possible.*

Communicable diseases: Chicken pox_____ Scarlet fever_____
Measles_____ Mumps_____
Other Illnesses: Strep infections_____, Tonsillitis_____, Lyme Disease _____
Frequent colds_____, ear infections_____, other_____
Surgical procedures:_____

_____

Injuries: (i.e. fractures concussions)_____
Physical limitations: _____
Allergies: _____
Deficiencies: Vision_____, Hearing_____, Speech_____
Eyes examined by an eye specialist? _____ If so, when_____
Wearing glasses?_____
Date of most recent dental check-up _____Dentist Name_____

HEALTH HABITS: Please check any that cause parental concern:
Elimination_____ Bedwetting_____ Diet_____ Appetite_____
Fears_____ Peer relations_____
Sibling rivalry _____Temper tantrums_____
Sleep_____Other_____
Indicate # of hours sleep averaged per night_____

MEDICATIONS: Does your child take daily medications?_____
If so, please list: _____

I give the school nurse permission to share pertinent health information with other essential staff members when *it is necessary to assist in meeting the health and educational needs of my child.*

*Signature of Parent or Guardian:*_____