**MENDHAM TOWNSHIP ELEMENTARY SCHOOL**

OFFICE OF THE PRINCIPAL
*Ms. Julianne Kotcho*

Kindergarten 2020-2021 School Year

Registration is underway for the 2020-2021 school year. Prospective Kindergarten students must turn 5 on or before October 1, 2020.

**Medical requirements for Kindergarten students:**

1) **Physical Exam Form (within prior year of starting the program)** (for Doctor clearance and any medical considerations/exceptions)

2) **Child's Health History Form** (filled out by parent)

3) **Immunization Documentation** (Minimum immunizations required by the State prior to starting):

    **DTap** - any child entering Pre-K needs a minimum of 4 doses
    **Polio** – minimum 3 doses
    **Measles/Mumps/Rubella** – any child > 15 mo. entering Pre-K needs 1 dose live vaccine
    **Varicella** – 1 dose or parent verification of having Varicella disease acceptable
    **Haemophilus Influenzae B (HIB)** -3 doses
    **Pneumococcal** – 3 doses
    **Influenza** – 1 dose annually (between September 1 and December 31) for students<5 yrs.

4) **Emergency Card completed with physician/medical group name**
(Sign consent and check off if your student may or may not have Tylenol or Advil.)

5) **Physician orders for any medications to be taken in school**
The School Nurse may not give any prescription medication without a doctor's order.

6) **Asthma and/or Allergy Action Plans and Medication Form**

7) **Epi Pen and Inhalers** must be in the original container, labeled with the student's name and the expiration date current.

***If you have any questions or to deliver and discuss any of these points, please contact me. I look forward to getting to know you and your child in the year to come.***

Sincerely,
Katelyn Safko, RN
MTES School Nurse

## *MENDHAM TOWNSHIP SCHOOLS*
## *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 _______ Vision Glasses
Throat___________Chest___________ Gums/teeth_______ near______ yes______
Abdomen________ Genitals________ Glands__________ far_______ no______ Feet____ Skin _____
Nutrition_______ Hearing
Blood pressure______Heart________ __________ right______
Healthy child? Yes_______ No ______ left _______
Allergies ___________________________________________________
Required Daily Medications_______________________________________
Special Problems/Physical Restrictions______________________________

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

| IMMUNIZATIONS | DATES | IMMUNIZATIONS | DATES |
|---|---|---|---|
| *DPT 1 | ______ | POLIO—(OPV) OR(IPV) (TYPE) | |
| *DPT 2 | ______ | *1__________ | ___________ |
| *DPT 3 | ______ | | |
| *DPT 4 | ______ | | |
| *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*_________________________________________