KINDERGARTEN MEDICAL RECORD
HILLSBOROUGH TOWNSHIP SCHOOL DISTRICT
379 South Branch Road Hillsborough NJ 08844

To be completed by Parent/Guardian (Kindly print) Date _____

Child's Last Name _____ First Name _____ Middle Name _____
Parent 1 Name _____ Parent 2 Name _____
Address _____ Hillsborough, NJ 08844
Date of Birth _____ Male ☐ Female ☐ Telephone # _____
Address _____ Telephone # _____

HEALTH HISTORY

Birth Weight _____ Type of Delivery: Vaginal ☐ C-Section ☐ Oxygen used: Yes ☐ No ☐
Condition at birth (jaundice, incubator, etc.) _____

_____

Complications during delivery _____

Age of Standing _____ Walking _____ Talking _____

1. Behaviors/Characteristics of note (comment in blank space)

Appetite	Fearfulness
Bowel/bladder control (age)	Nail biting
Disturbed sleep	Persistent crying
Easily distracted	Stubborn
Eating habits	Temper tantrums
Family history of color deficiency	Speech difficulties
Finger sucking	Independent

2. Dietary Restrictions: Please list, if any: _____

3. Has your child seen a dentist? Yes No

4. Does your child wear glasses? Yes No

5. Diseases

History	Year	History	Year	History	Year
Food Allergies		Drug Allergies		Auto Immune Disorder	
Non-Food/Non-Drug Allergies		Heart Disease		Strep Infections	
Asthma		Hepatitis		Juvenile Rheumatoid Arthritis	
Congenital Disorder		Lyme Disease		Autism Spectrum Disorders	
Convulsive Disorder		Mononucleosis		Hematological Disorders	
Diabetes		Neuromusc. Disease		ADD/ADHD	
Influenza (Flu)		Chronic Otitis Media		Other:	

6. Tuberculosis: Yes ☐ No ☐ Contact's Name _____ **Date** _____
7. Hospitalization (surgical/medical) _____
8. Significant Injuries _____
9. Pain: Joints _____ **Muscular** _____ **Other** _____
10. Frequency of: Sore Throat _____ **Earache** _____ **Colds** _____
11. Cough _____ **Headaches** _____ **Stomach Disorder** _____
12. Any special condition the school should be aware of: _____

I give permission to share medical information with the appropriate school staff: Yes ☐ No ☐

Parent/Guardian Signature: _____ **Date:** _____

HILLSBOROUGH TOWNSHIP PUBLIC SCHOOLS

IMMUNIZATION AND PHYSICAL EXAMINATION REPORT

STUDENT'S NAME: _____ **GRADE**: _____

DATE OF BIRTH: _____

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE ENTIRE FORM

This section MUST be completed in order for this form to be accepted!

Height: _____ Blood Pressure: _____ Hearing: R _____ L_____

Weight: _____ Pulse: _____ bpm Vision: R 20/_____ L20/_____
Correction Y/N Contact Y/N Eyeglasses Y/N

Indicators	Normal? (circle One)		Abnormal Findings/Comments
Head/Neck	YES	NO	
Eyes/ Sclera/Pupils	YES	NO	
Ears	YES	NO	
Nose/ Mouth/ Throat	YES	NO	
Heart: Murmurs/ Rhythms	YES	NO	
Lungs: Auscultation/Percussion	YES	NO	
Chest Contour	YES	NO	
Skin	YES	NO	
Abdomen: Assessment (inc. liver, spleen)	YES	NO	
Tanner Stage: Testes/Onset of Menses	YES	NO	
Hernia? (if yes/possible, please explain)	YES/ possible	NO	
Neck/Back/Spine: Range of Motion	YES	NO	
Scoliosis	YES	NO	
Upper Extremities	YES	NO	
Lower Extremities	YES	NO	
Neurological Balance & Coordination:	YES	NO	
Romberg	YES	NO	
Heel Walk	YES	NO	
Tandem Walk	YES	NO	
Nose Touch	YES	NO	
Toe Walk	YES	NO	

NOTE: Must be completed within 365 days of the first day of school to be acceptable.

HILLSBOROUGH TOWNSHIP PUBLIC SCHOOLS

IMMUNIZATION AND PHYSICAL EXAMINATION REPORT

STUDENT'S NAME: _____ **GRADE**: _____

DATE OF BIRTH: _____

Medications currently in use:
ATTACH COPY OF COMPLETE IMMUNIZATION RECORD
Allergies: Yes / No LIST Allergies, if any:
Additional Comments:

General Diagnosis: _____

Recommendations: _____

_____

_____

EXAMINED BY: Health Care Provider _____
School Physician _____

I hereby certify that the above named student was examined by me and found physically fit to engage in all physical activity, including physical education and recess.

Health Care Provider's Signature_____
Circle ONE: MD DO NP PA

EXAMINATION DATE: _____

PLEASE STAMP WITH OFFICE STAMP ↑

NOTE: Must be completed within 365 days of the first day of school to be acceptable.

IMMUNIZATION REQUIREMENTS TO ATTEND A NJ SCHOOL

The New Jersey State Department of Health has **mandated** minimum immunization regulations, which apply to all students attending any public or private school in New Jersey.

DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE

Students less than seven years of age, four doses of DTP, one dose of which shall be given on or after the fourth birthday.

Students seven years of age or older, three doses of tetanus-diphtheria (adult Td) or combination of DTP and Td/DT to total three doses shall meet the DTP requirements.

Students born on or after January 1,1997 and entering Grade 6, one dose of Tdap.

POLIOVIRUS VACCINE

Students less than seven years of age, shall receive at least three doses of live, trivalent, oral poliovirus vaccine (OPV) or IPV, one dose of which shall be given on or after the fourth birthday.

Students seven years of age and older, three doses of oral polio vaccine or enhanced IPV will satisfy the polio vaccine requirement.

MEASLES VACCINE

Every student born **on or after January 1, 1990**, shall have **received two doses** of measles virus vaccine, **administered on or after the first birthday.**

RUBELLA VACCINE

Every student shall have **received one dose** of live rubella virus vaccine, **administered on or after the first birthday.**

MUMPS VACCINE

Every student shall have **received one dose** of live mumps virus vaccine, **administered on or after the first birthday.**

VARICELLA VACCINE

Every student born **on or after January 1, 1998**, shall have **received one dose** of varicella vaccine, **administered on or after the first birthday**, prior to school entrance for the first time.

HEPATITIS B VACCINE

Every student must receive three doses of Hepatitis B vaccine appropriately spaced.

MENINGOCOCCAL VACCINE

Every student born **on or after January 1, 1997 and 11 years of age and attending 6th Grade** shall have **received one dose** of meningococcal vaccine.

MANTOUX TEST

Students born in a NJ Dept. of Health and Senior Services identified country and entering school in the U.S. for the first time, regardless of age or grade are required to have a Mantoux intradermal test.

NOTATIONS

These immunization requirements are applicable to all children attending any public or private school. A pupil may be admitted on a provisional basis with written documentation from a physician or public health agency certifying that the immunizations are in the process of being administered