Central Registration
2175 Lemoine Ave.
(201) 585-4612 Ext 7506
Fax (201) 585-7997

MEDICAL FORM REQUIREMENTS

DOCTOR'S CERTIFICATE MUST SHOW A MINIMUM OF:

- DATES (MONTH, DAY AND YEAR) OF **3 DPT** IMMUNIZATIONS **AND A BOOSTER DOSE**. THE BOOSTER MUST BE GIVEN ON OR AFTER THE 4TH BIRTHDAY.

- DATES (MONTH, DAY AND YEAR) OF **2 POLIO** IMMUNIZATIONS **AND A BOOSTER DOSE**. THE BOOSTER MUST BE GIVEN ON OR AFTER THE 4TH BIRTHDAY.

- DATE (MONTH, DAY AND YEAR) OF **MEASLES** IMMUNIZATION GIVEN ON OR AFTER THE 1ST BIRTHDAY, **AND A SECOND DOSE** GIVEN AFTER AT LEAST ONE MONTH.

- DATE (MONTH, DAY AND YEAR) OF **RUBELLA (**GERMAN MEASLES) IMMUNIZATION GIVEN ON OR AFTER THE 1ST BIRTHDAY.

- DATE (MONTH, DAY AND YEAR) OF **MUMPS** IMMUNIZATION GIVEN ON OR AFTER THE 1ST BIRTHDAY.

- DATE (MONTH, DAY AND YEAR) OF **VARICELLA** (CHICKEN POX) IMMUNIZATION GIVEN ON OR AFTER THE 1ST BIRTHDAY.
  THIS IS REQUIRED FOR ALL CHILDREN BORN ON OR AFTER JANUARY 1, 1998.

- DATES (MONTH, DAY AND YEAR) OF **3 HEPATITIS B** IMMUNIZATIONS.

- **ADDITIONALLY FOR STUDENTS ENTERING GRADES 6 – 12:**
  - DATE (MONTH, DAY AND YEAR) OF **Tdap** IMMUNIZATION GIVEN AFTER THE 10TH BIRTHDAY.
  - DATE (MONTH, DAY AND YEAR) OF **MENINGOCOCCAL** IMMUNIZATION GIVEN AFTER THE 10TH BIRTHDAY.
  -

- **ADDITIONALLY FOR STUDENTS ENTERING PRE-SCHOOL:**
  - DATES (MONTH, DAY AND YEAR) OF **HAEMOPHILUS B (HIB)** VACCINES WITH ONE DOSE GIVEN AFTER THE 1ST BIRTHDAY.
  - DATES (MONTH, DAY AND YEAR) OF **PNEUMOCOCCAL (PCV-13)** VACCINES WITH ONE DOSE GIVEN AFTER THE 1ST BIRTHDAY.
  - DATE (MONTH, DAY AND YEAR) OF ANNUAL INFLUENZA VACCINE.

- **FOR STUDENTS ENTERING FROM OUTSIDE THE UNITED STATES:**
  - DATE (MONTH, DAY AND YEAR) AND RESULT OF **MANTOUX TUBERCULIN SKIN TEST DONEWITHIN 6 MONTHS PRIOR TO ENTERING SCHOOL.**

  - A SEPARATE REPORT OF **X-RAY RESULTS** SUBMITTED BY THE RADIOLOGIST **IF THE MANTOUX TUBERCULIN TEST IS POSITIVE**.

- **ALL REGISTRANTS MUST HAVE A PHYSICAL EXAMINATION BY THEIR FAMILY PHYSICIAN WITHIN 365 DAYS PRIOR TO ENTERING SCHOOL.**

THE COMPLETED PHYSICAL EXAMINATION FORM MUST BE RETURNED WITH THE REGISTRATION PACKET.

FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY

PHYSICAL EXAMINATION FOR REGISTRATION

Student' s Name: _____ **Sex: M** ___ **F** ___ **X** ___ **Date of Birth:** _____

Address: _____ **School:** _____ **Grade / Teacher:** _____

Parent / Guardian's Name: _____ **Telephone:** _____

EXAMINATION

EYES		HEART		ALLERGIES		HEIGHT	
EARS		LUNGS		NUTRITION		WEIGHT	
NOSE		ABDOMEN		NERV.SYS			
THROAT		GENITALIA		COORDINATION		B.P.	
TEETH		HERNIA		SCOLIOSIS		VISION	
SKIN		LYMPH NODES		FEET		HEARING	

IMMUNIZATIONS - VACCINES

VACCINE TYPE	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr
Diphtheria, Tetanus & Pertussis (DTaP/ DT/ Td)						
Tdap--booster (after age 10)			**Meningococcal (**after age 10**)**			
Polio (IPV / OPV) - indicate						
MMR (combination)*				***if immune, attach serology titers report**		
If single doses enter here:	Measles*		Rubella*		Mumps*	
Haemophilus B (HIB)**						
Hepatitis B - 3 doses						
Varicella (after 1st birthday)			**Varicella Disease:**			
Pneumococcal conjugate**						
Influenza vaccine**						
Hepatitis A - 2 doses***			****required for pre-school**	****not required**		
Other (type/date)	:	:	:	:	:	:

Mantoux Tuberculin Test: Date done: _____ Date read: _____ Result: _____ mm

Chest X-Ray: Date: _____ Results: _____ INH: Date begun: _____ Dosage: _____

HEALTH HISTORY (DATES) : *PLEASE ATTACH COMPLETE HISTORY AND RECOMMENDATIONS*

Allergies	Asthma	Mononucleosis	Congenital Defects (type)
Drug Sensitivity	Seizure Disorder	Immunodeficiency	
Otitis Media	Diabetes	Other:	Operations / Injuries (dates)
Strep Infections	Heart Disease		
Hepatitis	Neuromusc. Dis.		

1. General Health: _____
2. May_____ May not_____ participate in all physical activities. (specify limitations)
3. Is_____ Is not_____ taking medication.
4. Medication: _____ Dosage: _____
5. **Lead testing** Date: _____ Level: _____
6. Other Tests done: _____

ALL NEW REGISTRANTS TO FORT LEE PUBLIC SCHOOLS MUST HAVE A PHYSICAL EXAMINATION WITHIN 365 DAYS PRIOR TO ENTERING SCHOOL

PHYSICIAN'S NAME/ADDRESS (STAMP) _____ PHYSICIAN'S SIGNATURE _____ DATE of EXAM

IMPORTANT MEDICAL INFORMATION REQUIRED

FORT LEE SCHOOL DISTRICT FORT LEE NEW JERSEY

Dear Parents/Guardians:

The Fort Lee School District **requires a written annual update** of the condition of students who have any one of the following:

1. **ALLERGIES: FOOD PRODUCTS, INSECTS, LATEX, MEDICATIONS, ETC.**
2. **ASTHMA AND OTHER LUNG DISORDERS**
3. **BLOOD DISORDERS**
4. **CARDIAC DISORDERS**
5. **DIABETES**
6. **ORTHOPEDIC DISORDERS**
7. **SEIZURE DISORDER**
8. **OTHER CONDITIONS REQUIRING REGULAR MEDICAL ATTENTION INCLUDING PSYCHIATRIC/EMOTIONAL DISORDERS**
9. **DAILY PRESCRIBED MEDICATION: HOME OR SCHOOL**
10. **RECENT HOSPITALIZATIONS OR SURGICAL PROCEDURES**

Updated documentation regarding your child's condition is required each year. Acceptable documentation is a **full physical examination report or a written statement from your attending physician** detailing current level of health and special needs or considerations. The physician must **SIGN, STAMP, and DATE the form.** Submitted information may be shared with school physicians and/or nurses.

Either document must be submitted to the school nurse-teacher in your child's school as soon as possible at the beginning of the school year.

Your compliance in this process will greatly assist the school district in providing the safest environment for your child. We appreciate your cooperation.

Sincerely yours,

Maryann J. Colenda, M.D.
Jen F. Lee, M.D.

Check appropriate response below *and return to student's teacher on the first day of school*.

My child, _____, **does** have a medical condition as noted above.
I will submit a physician's report promptly.

My child, _____, **does not** have any known medical conditions.

_____	_____	_____	_____
[PRINT student's first & last name]	[grade/teacher]	[parent/guardian signature]	[date]

Rev. 6-16

FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY

STUDENT MEDICAL HISTORY

MUST BE COMPLETED BY PARENT OR GUARDIAN.

Student' s Name _____
Date of Birth _____
Parent / Guardian _____
Grade / Teacher _____ **School** _____

PLEASE CIRCLE ANSWERS TO THE FOLLOWING:
(EXPLAIN YES ANSWERS BELOW and on reverse if necessary)

The student named above:

1. has had injuries requiring medical attention: ..... YES NO
type(s) & date(s) _____

2. has had special health problems or difficulty : ..... YES NO
type(s) & date(s) _____

3. is under a physician's care for a medical condition : ..... YES NO
type & date _____

4. takes medication : ..... YES NO
type / dose _____
reason _____

5. wears corrective lenses : ..... YES NO
(circle) glasses contact lenses since _____

6. has a hearing problem : ..... YES NO
explain: _____

7. has had surgical operations: ..... YES NO
type(s) & date(s) _____

8. has been hospitalized : ..... YES NO
when & why _____

*** Do you know of any reason why this individual should NOT participate in all physical education activities ? ..... YES NO**

*** Is this student subject to any condition which may create a classroom emergency, such as seizure disorder, fainting spells, diabetes, allergies, asthma, etc? ..... YES NO**

EXPLAIN _____

If this student has had any of the following illnesses, please indicate the year(s) below.

	YEAR		YEAR
Chicken Pox	_____	**Strep Throat**	_____
Whooping Cough	_____	**Scarlet Fever**	_____
Measles	_____	**Rheumatic Fever**	_____
Mumps	_____	**Lyme Disease**	_____
Rubella	_____	**Pneumonia**	_____
Hepatitis (type___)	_____	**Other** _____	_____
Immunodeficiency (HIV)	_____		

Signature of Parent / Guardian **Date**