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.
- 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 done within 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.

REV. 2-12  CR-03
**PHYSICAL EXAMINATION FOR REGISTRATION**

<table>
<thead>
<tr>
<th>EXAMINATION</th>
<th>IMMUNIZATIONS - VACCINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>EYES</td>
<td>HEART</td>
</tr>
<tr>
<td>EARS</td>
<td>LUNGS</td>
</tr>
<tr>
<td>NOSE</td>
<td>ABDOMEN</td>
</tr>
<tr>
<td>THROAT</td>
<td>GENITALIA</td>
</tr>
<tr>
<td>TEETH</td>
<td>HERNIA</td>
</tr>
<tr>
<td>SKIN</td>
<td>LYMPH NODES</td>
</tr>
</tbody>
</table>

**IMMUNIZATIONS - VACCINES**

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

**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**

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Asthma</th>
<th>Mononucleosis</th>
<th>Congenital Defects (type)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Sensitivity</td>
<td>Seizure Disorder</td>
<td>Immunodeficiency</td>
<td></td>
</tr>
<tr>
<td>Otitis Media</td>
<td>Diabetes</td>
<td>Heart Disease</td>
<td>Other:</td>
</tr>
<tr>
<td>Strep Infections</td>
<td></td>
<td></td>
<td>Operations / Injuries (dates)</td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neuromusc. Dis.</td>
<td></td>
</tr>
</tbody>
</table>

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**

rev 3/11 02-D-01
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]
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 _____________

rev. 2 / 07 02-D-04