St. Augustine of Canterbury School

A National Blue Ribbon School

Member of NCEA & AdvancED Accredited

45 Henderson Road • Kendall Park, New Jersey 08824

(732) 297-6042 • Fax (732) 297-7062

Students Entering Kindergarten Immunization Requirements

Dear Parents:

Immunization Requirements are mandated by the State of New Jersey and the South Brunswick Department of Health. Students are ***Not*** allowed to remain in school if all requirements have not been met by November 30.

Students entering Kindergarten must have a History and Physical Exam on file and provide proof of the age appropriate vaccinations for the following:

1. DTap/DTP: 4 (loses with booster given on or after the 4th birthday or any 5 doses
2. Polio: 3 doses with one dose given on or after the 4th birthday or any 4 doses
3. Measles: 2 doses on or after the 1st birthday *with* at least one month interval between Doses; Laboratory proof of immunity is acceptable.
4. Rubella and Mumps: At least 1 dose on or after the 1st birthday. Laboratory proof of immunity is acceptable
5. Varicella (Chicken Pox): 1 dose on or after the first birthday; Date of disease or Laboratory proof of immunity is acceptable
6. Hepatitis B: 3 doses appropriately spaced

History and Physical Exams as well as Over the Counter Medication Forms, Food Allergy and Asthma Forms are available on the school website. All Medication forms as well as Food Allergy and Asthma Forms must be updated yearly and may be faxed to the school office if your pediatrician allows this to be faxed with your permission to 732-297-7062. Please do not hesitate to call if you have any questions.

Sincerely,

Donna Hermosilla, RN

Mrs. Donna Hermosilla,
R.N School Nurse

St. Augustine of Canterbury Health History Form

Please Have Physician Fill Out and Sign; Form Must Be On file By the First Day of School

Student Name:_____ **M__F__Date of Birth**_____

Please Circle No or Yes and Provide Any Explanation of Medical Conditions:

Hospitalization/Surgery	**No**	**Yes**_____
Asthma:	**No**	**Yes**_____
Food Allergies:	**No**	**Yes**_____
Insect/ Bee Allergies	**No**	**Yes**_____
Seasonal Allergies:	**No**	**Yes**_____
Heart Condition:	**No**	**Yes**_____
Vision Problems:	**No**	**Yes**_____
Wears Glasses/Contacs:	**No**	**Yes**_____
Hearing Disorder:	**No**	**Yes**_____
Diabetes:	**No**	**Yes**_____
Seizure Disorder:	**No**	**Yes**_____
Bleeding Disorder:	**No**	**Yes**_____
Muscular Problem:	**No**	**Yes**_____
Orthopedic Problem:	**No**	**Yes**_____
Headaches/Nose Bleeds	**No**	**Yes**_____
Stomach/GI Problem	**No**	**Yes**_____
Other Conditions	**No**	**Yes**_____

List Medications or Special Dietary Needs_____

Student May Participate Fully in all Physical Activities with No Restrictions: Yes No
Explanation of limitations if indicated:_____

_____

Physician Signature_____ **Date**_____

ST. AUGUSTINE OF CANTERBURY SCHOOL
45 HENDERSON ROAD
KENDALL PARK, NJ 08824
PHONE (732) 297-6042 FAX (732) 297-7062

MEDICAL EXAMINATION OF STUDENT BY PRIVATE PHYSICIAN
(Please Print)

Student's Name: _____ Date of Exam: _____

Physician Name: _____ Phone #: _____

Immunization(s) and/or test(s) given on this date: _____

_____

Significant Factors in Home Situation: _____

_____

Please indicate below by check, any positive findings and describe fully in the section on the right.

Exam		Description	Treatment Advised
Skin			
Eyes			
Ears			
Nose & Throat			
Mouth			
Glands			
Heart			
Lungs			
Abdomen			
Hernia			
Orthopedic			
Genito-Urinary			
Nutriton			
Other			

Vision (if done) R: _____ L: _____
Hearing (if done): R: _____ L: _____
Blood Pressure: _____

Height: _____
Weight: _____
Scoliosis: Negative: _____
Positive: _____

Student may have age/weight appropriate dosage of Tylenol for occasional headache without fever.
Parents are informed of time administered. Yes ___ No ____

Specify medical recommendations to School for academic and activity programs (use additional paper if necessary).

Examining Physician: _____ License #: _____
Address: _____ Phone #: _____

Please attach a copy of Immunization Record

St. Augustine of Canterbury School
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Phone: 732-297-6042 Fax: 732-297-7062

Authorization to Administer Medication In School
(To Be Kept Confidential Upon Completion)

Student Name: _____ Grade: _____

Diagnosis/Illness: _____

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Special Directions: _____

Possible Side Effects: _____

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I certify that the above information regarding this student is correct, and that administration of the medication to this student is necessary.

Signature of Prescribing Physician: _____ Date: _____

Address: _____ Phone #: _____

I/We authorize the School Nurse or, in his/her absence, another school employee designated and trained by the School Nurse to administer the above medication(s) as indicated. I/We understand and agree that the School, the School Nurse and its employees shall not be liable for any injury to the Student resulting from the administration of the medication(s) as authorized by my signature below.

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

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

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Authorization Form for Over-the-Counter Medications

Student Name: _____

Over –the-counter medications must have a physician's approval and parent/guardian permission to be administered. Below is a list of common over-the-counter medications that may be needed occasionally throughout the day. Please have your ***physician*** fill out and sign the form if you would like these medications available for your child:

Tylenol or Acetaminophen (include dosage) _____

Motrin or Ibuprofen (include dosage) _____

Benadryl or Antihistamine (include dosage) _____

Tums (include dosage) _____

Cough Drops/Throat Soothers (include dosage) _____

Calamine Lotion (include dosage) _____

Saline or Other Eye Rinse (include dosage) _____

Physician's Signature: _____ Date: _____

I/We authorize the School Nurse or, in his/her absence, another school employee designated and trained by the School Nurse to administer the above medication(s) as indicated. I/We understand and agree that the School, the School Nurse and its employees shall not be liable for any injury to the Student resulting from the administration of the medication(s) as authorized by my signature below.

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