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

Pre-K Medical and Immunization Requirements

Dear Parents:

Immunization requirements for school attendance are regulated by the State of New Jersey and the South Brunswick Department of Health.

Health History and Physical Exam Forms are required for all Pre-K students. Enclosed is a copy of the age appropriate required immunizations including: Dtap, Polio, MMR, Hib, Chicken pox, PCV, and Flu Vaccine for Pre-K admission. ***All immunizations, including the Flu vaccine, must be administered by December 1st***. A Provisional Admittance form must be signed by your Physician in order for your child to remain in school if your child is not up to date by December 1st.

If your child has Food Allergies, Asthma, or other Medical Conditions, please consult with the school nurse regarding the appropriate forms required.

If you have any questions, please do not hesitate to call. The health and well being of your child are of the utmost importance.

Sincerely,

Mrs. Donna Hermosilla, R.N.

School Nurse

FOR CHILD CARE/PRESCHOOL DIRECTORS AND PARENTS: CHILD CARE/PRESCHOOL IMMUNIZATION REQUIREMENTS

NJ Department of Health
Vaccine Preventable Disease Program

New Jersey Minimum Immunization Requirements for Child Care/Preschool Attendance
N.J.A.C. 8:57-4 Immunization of Pupils in School

Listed in the chart below are the minimum required number of doses your child must have in order to enroll/attend a child care/preschool facility in NJ. Additional vaccines are recommended by the Advisory Committee on Immunization Practices (ACIP), but only the following are required for child care/preschool attendance in NJ. For the complete ACIP Recommended Immunization Schedule, please visit http://www.cdc.gov/vaccines/schedules/index.html

At this age the child should have received the following vaccines:	**2 months**	**4 months**	**6 months**	**12 months**	**15 months**	**18 months**	**19 months**	**20-59 months**
Diphtheria, tetanus & acellular pertussis (DTaP)	Dose #1	Dose #2	Dose #3			Dose #4		
Inactivated Poliovirus (Polio)	Dose #1	Dose #2				Dose#3		
Haemophilus influenzae type b (Hib)	Dose #1	Dose #2		1-4 doses* (see footnote)		At least 1 dose given on or after the first birthday		
Pneumococcal conjugate (PCV 13)	Dose #1	Dose #2		1-4 doses* (see footnote)	At least 1 dose given on or after the first birthday			
Measles, mumps, rubella (MMR)					Dose #1†			
Varicella (VAR)							Dose #1 §	
Influenza (IIV; LAIV)			One dose due each year ¶					

Interpretation: Children need to receive the minimum number of age-appropriate vaccines prior to entering child care/preschool. For example, a child 2 months of age, must have 1 dose each of DTaP, Polio, Hib, and PCV before being permitted to enter child care/preschool. A child entering at a younger age range than listed above must have proof of receiving vaccines in the previous age bracket. Example: A child entering child care/preschool at 11 months of age, would need at least the following: 3 DTaP, 2 Polio, 2 Hib, and 2 PCV. The current seasonal flu vaccine is required every year by December 31 for children 6-59 months of age.

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
45 Henderson Road
Kendall Park, NJ 08824
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: _____

****

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:* _____

St. Augustine of Canterbury School
45 Henderson Road
Kendall Park, NJ 08824
Phone: 732-297-6042 Fax: 732-297-7062

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:* _____