



St. Ann Classical Academy

40 Second Avenue | Raritan, NJ 08869 | P: 908-725-7787 | F: 908-541-9335 | www.stannclassical.org

To All Parents/Guardians of students entering Pre-K, K, 1st, 3rd, & 6th grades, as well as all new students to St. Ann Classical Academy:

Please be advised that physical exams are **mandatory** for students who are **new to St. Ann Classical Academy and/or entering Pre-K, K, 1st, 3rd, & 6th grade.** However, a yearly physical is recommended!

Completed physical forms are due back to the Nurse on the first day of school.

Current immunization records are also mandatory in order to maintain attendance in school. Failure to comply with these requirements will jeopardize your child remaining in school until all forms are updated and received.

***Physical forms and 6th grade immunization forms are available on the school website.**

For those students whose physical exams are scheduled to be performed after the start of school in September (in accordance with your insurance company's calendar year), please have the physical scheduled and send a note on the first day of school noting the child's name AND the date for which the physical is scheduled. Please send in the completed form after the physical is completed.

Your cooperation and compliance enables us to stay informed of your child's health status and any associated needs. Please be sure to notify the nurse of any changes in your child's medical information throughout the school year, particularly medications or allergies.

Thank you in advance for your attention to these matters.

School Nurse, St. Ann Classical Academy



St. Ann Classical Academy

40 Second Avenue | Raritan, NJ 08869 | P: 908-725-7787 | F: 908-541-9335 | www.stannclassical.org

PHYSICAL FORM

Name: _____ Birthdate: _____ Age: _____ Grade in Sept. _____

Allergies: _____

Will your child need: _____ Inhaler; _____ EpiPen _____; Benadryl; _____ Other medications (please list) _____ during the school day or to be kept in school for emergency use? (please check all that apply. The necessary paperwork will then be sent home for you and your healthcare provider to complete).

HEIGHT: _____ WEIGHT: _____ B/P: _____ SPECIAL CONCERNS: _____

Please list any significant illnesses, accidents, operations, congenital abnormalities, family history, activity restrictions, etc.

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	LEAD SCREENING	
						Test Date	Result
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT, indicate in corner box)							
Tdap							
POLIO – INACTIVATED POLIO VACCINE (IPV) <i>If oral vaccine, indicate (OPV) in corner box</i>							
MEASLES, MUMPS, RUBELLA (MMR)							
HAEMOPHILUS B (HIB)**						Document below single antigen vaccine receipt, serology titers, or varicella disease history	
HEPATITIS B						Hepatitis B	Date: _____ Titer: _____
VARICELLA						Varicella	Date: _____ Titer: _____
PNEUMOCOCCAL CONJUGATE **							
MENINGOCOCCAL							
HEPATITIS A ***						Measles	Date: _____ Titer: _____
HPV (HUMAN PAPILLOMAVIRUS) ***						Mumps	Date: _____ Titer: _____
OTHER						Rubella	Date: _____ Titer: _____
OTHER							

Provisional admission attached–Date Granted _____ Medical exemption attached _____ Religious exemption attached _____

HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR
FOOD ALLERGIES		DIABETES		LYME DISEASE		JUVENILE RHEUMATOID ARTHRITIS	
NON-FOOD/NON-DRUG ALLERGIES		INFLUENZA (FLU)		MONONUCLEOSIS		AUTISM SPECTRUM DISORDERS	
		OTHER		NEUROMUSC. DISORDER		HEMATOLOGICAL DISORDERS	
ASTHMA		DRUG ALLERGIES		CHRONIC OTITIS MEDIA		ADD/ADHD	
CONGENITAL DISORDER		HEART DISEASE		AUTO IMMUNE DISORDERS		CONCUSSION/TBI	
CONVULSIVE DISORDER		HEPATITIS		STREP INFECTIONS			

PHYSICAL FINDINGS (Please list any positive findings and treatment advised) DATE OF EXAM: _____

EENT _____

SPEECH _____ TEEH-MOUTH _____ NUTRITION _____ ABDOMEN _____ HERNIA _____

HEART/CARDIAC _____ LUNGS/PULMONARY _____

GU _____ GI _____ ENDOCRINE _____ THYROID _____

NERVOUS SYSTEM _____ LYMPH GLANDS _____ SKIN _____

ORTHOPEDIC (Feet) _____ (Posture) _____ (Structural) _____ (Other) _____

Signature of Examining Healthcare Provider (MD, DO, NP, PA) _____

OFFICE STAMP



St. Ann Classical Academy

40 Second Avenue | Raritan, NJ 08869 | P: 908-725-7787 | F: 908-541-9335 | www.stannclassical.org

Dear Parents/Guardians:

The following is a list of immunizations **required** by the State of New Jersey for admittance into school:

For Pre-K:

- **Haemophilus B (HIB)** — one dose after 1st birthday
- **Pneumococcal Conjugate** — one dose after 1st birthday
- **DTaP** — four doses
- **Polio** — three doses
- **MMR** — one dose on or after 1st birthday
- **Varicella (Chicken Pox)** — one dose on or after 1st birthday
- **Influenza** must be between Sept. 1st – Dec. 31st of the current school year

For Kindergarten:

- **MMR** (Measles, Mumps, Rubella) — two doses or one each of live Rubella and live Mumps containing vaccine and two doses of live Measles containing vaccine (lab evidence of immunity is also acceptable)
- **Varicella** — One dose on or after 1st birthday (physician or parental statement of previous varicella, aka chickenpox, the disease is also acceptable)
- **DTaP (Diphtheria, Tetanus, Pertussis)** — 4/5 doses: four doses with one given on or after 4th birthday or any five doses
- **Polio** — 3/4 doses: three doses with one dose given on or after 4th birthday or any four doses
- **Hepatitis B** — three doses or two doses of adolescent formulation between ages of 11-15 if not previously vaccinated

Additionally for the Sixth Grade:

- **Tdap** (entering 6th grade)
- **Meningococcal Conjugate** (entering 6th grade)

For further information, view the N.J. Dept. of Health and Senior Services website.



St. Ann Classical Academy

40 Second Avenue | Raritan, NJ 08869 | P: 908-725-7787 | F: 908-541-9335 | www.stannclassical.org

Dear Parents/Guardians:

Please be advised that the New Jersey State Department of Health and Senior Services and the Center for Disease Control and Prevention states the following vaccines are **MANDATED** for all students born on or after January 1, 1997 and entering 6th grade after Sept. 1, 2008.

- **One dose of tetanus, diphtheria, acellular pertussis (Tdap) given at least 5 years after the last dose of DTP**
- **One dose of Meningococcal Conjugate vaccine**

Students will not be allowed to attend school in September if the above requirements are not met. Your cooperation is appreciated.

Sincerely,

School Nurse, St. Ann's

Please consult your physician/health care provider and return this form along with the completed physical form to the Health Office **no later than the first day** of the school year.

NAME _____

Received: _____ Date: _____

Name of vaccine

Received: _____ Date: _____

Name of vaccine

Administered by: _____

Physician/Provider Signature

OFFICE STAMP HERE PLEASE: