Central Registration

231 Main Street, 3rd Floor

(201) 585 – 4612 Ext. 7506

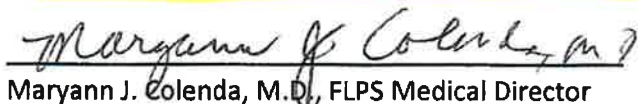
Fax (201) 585 -7997

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.
- DATES (MONTH, DAY AND YEAR) OF **VARICELLA** (CHICKENPOX) 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 **MENINGOCOCOCCAL** IMMUNIZATION GIVEN AFTER THE 10TH BIRTHDAY.
- **ADDITIONALLY FOR STUDENTS ENTERING PRE-SCHOOL:**
  - DATE (MONTH, DAY AND YEAR) OF **HAEMOPHILUS B (HIB)** VACCINES WITH ONE DOSE GIVEN AFTER THE 1ST BIRTHDAY.
  - DATE (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 TEST DONE WITHIN 6 MONTHS PRIOR TO ENTERING SCHOOL.**
  - A SEPARATE REPORT OF **CHEST X-RAY RESULTS** SUBMITTED BY THE RADIOLOGIST **IF THE MANTOUX TUBERCULIN TEST IS POSITIVE.**
  - PHYSICAL EXAMINATION PERFORMED BY A LICENSED UNITED STATES HEALTHCARE PROVIDER.

- **ALL REGISTRANTS MUST HAVE A PHYSICAL EXAMINATION BY THEIR PRIMARY HEALTHCARE PROVIDER WITHIN 365 DAYS PRIOR TO ENTERING SCHOOL.**



Maryann J. Colenda, M.D., FLPS Medical Director

FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY
FORM 02-D-02

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☒ **Immunization record must be attached to this form.**

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

FORT LEE SCHOOL DISTRICT
FORT LEE NEW JERSEY
FORM 02-D-33R

IMPORTANT MEDICAL INFORMATION REQUIRED FOR REGISTRATION

Dear Parents/Guardians:

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

1. **ALLERGIES (INCLUDING BUT NOT LIMITED TO: 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 DISORDERS**
8. **OTHER CONDITIONS REQUIRING REGULAR MEDICAL ATTENTION INCLUDING PSYCHIATRIC/EMOTIONAL DISORDERS**
9. **DAILY PRESCRIBED MEDICATION FOR HOME OR SCHOOL REGARDING ANY OF THE ABOVE**
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 the Student Medical Report form** detailing current level of health and special needs or considerations. Either document must be submitted to the certified school nurse 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.

Maryann J. Colenda, M.D., Medical Director
Jen F. Lee, M.D., School Physician

Check appropriate response below.

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

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

______________________	______________	______________
PRINT STUDENT'S NAME	DOB	DATE

______________	______________________
GRADE	TEACHER

______________________	______________________
PARENT/GUARDIAN SIGNATURE	PARENT/GUARDIAN PRINTED NAME

REV. 03/2022

FORT LEE SCHOOL DISTRICT
FORT LEE, NEW JERSEY
STUDENT MEDICAL HISTORY
FORM 02-D-04

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 above named student:

1. has had injuries requiring medical attention: .... YES NO
   Detail(s) & Date(s)________________________________
2. has had special health problems or difficulty: .... YES NO
   Detail(s) & Date(s) ________________________________
3. is under a physician's care for a medical condition: .... YES NO
   Detail(s) & Date(s) ________________________________
4. takes medication: .... YES NO
   Name & Dose________________________________
   Reason________________________________
5. wears corrective lenses: .... YES NO
   (Circle) Glasses Contact Lenses Starting Date______________
6. has a hearing problem: .... YES NO
   Explain: ________________________________
7. has had surgical operations: .... YES NO
   Detail(s) & Date(s) ________________________________
8. has been hospitalized: .... YES NO
   Detail(s) & Date(s) ________________________________

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

*Is this student subject to any condition which may create a classroom emergency, such as but not limited to: seizure disorder, fainting spells, diabetes, allergies, asthma, etc? .... YES NO
PLEASE EXPLAIN________________________________

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

	YEAR		YEAR
Chicken Pox	________	Step Throat	________
Whooping Cough	________	Scarlet Fever	________
Measles	________	Rheumatic Fever	________
Mumps	________	Lyme Disease	________
Rubella	________	Pneumonia	________
Hepatitis (type________)	________	Other____________	________

________________________ ________________________ ____________
Parent/Guardian Signature Parent/Guardian Printed Name Date

REV. 9/09/19