

TOMS RIVER SCHOOLS
 Required Pre-School Physical Examination for Pupils Entering **KINDERGARTEN**

Child's Name: (Last, First, Middle) _____

Address: _____ City/State: _____ Phone: _____

Birth Date: _____ Birth Wt: _____ Male: _____ Female: _____

Parent's Name: _____

CODE: 0 – No Defect

1 – Slight Deviation

2 – Requires Attention

E.N.T. R _____ L _____	Heart _____	Spine _____	Height _____
Vision R _____ L _____	Lungs _____	Posture _____	Weight _____
Hearing R _____ L _____	Abdomen _____	Extremities _____	
Teeth _____	Hernia _____	B.P. _____	Glands _____

ILLNESSES:

Chicken Pox _____	Mumps _____	Pneumonia _____	Heart Disease _____
Measles _____	Convulsions _____	Allergies _____	T.B. Contact _____
German Measles _____	Diabetes _____	Scarlet Fever _____	Operations _____
Rheumatic Fever _____	Ear Trouble _____		

VACCINE TYPE	1 ST DOSE MO/DAY/YR	2 ND DOSE MO/DAY/YR	3 RD DOSE MO/DAY/YR	4 TH DOSE MO/DAY/YR	5 TH DOSE MO/DAY/YR	MO/DAY/YR
DIPHTHERIA, TETANUS, PERTUSSIS (DTP) (If Td, DtaP, or Dt*, (Indicate in corner box) One dose on or after fourth birthday.						
POLIO ORAL POLIO VACCINE (OPV) (If Salk Vaccine, indicate IPV in corner box) One dose on or after fourth birthday.						
MEASLES, MUMPS, RUBELLS (MMR) On or after first birthday						
MEASLES (Two doses required)				MEASLES SEROLOGY	DATE	TITER
RUBELLA				RUBELLA SEROLOGY	DATE	TITER
MUMPS				MUMPS SEROLOGY	DATE	TITER
HAEMOPHILUS B (HIB) **						
HEPATITIS B ***						
VARICELLA (Chicken Pox)						
INFLUENZA						
PNEUMOCOCCAL						
Mantoux Tuberculin Test – Date: Only as Required by State Law for Transfer Students						

Recommendations or restrictions concerning this student: _____

Physician's Signature: _____

Date of well child physical: _____

Physician's Stamp:

ELEMENTARY HEALTH OFFICE/NEW ENTRANT QUESTIONNAIRE

Student's Name _____ ID# _____ D.O.B. _____
Birthplace _____ Age _____ Sex _____ Grade _____

Please check the following questions and explain any "Yes" answer on the space provided.

MEDICATIONS:

Does your child take any daily medications? Yes _____ No _____

If Yes, please list daily medications and doses: _____

Will your child require medication given in school? Yes _____ No _____

ALLERGIES: Is your child allergic to any of the following:

Medications: Yes _____ No _____

If Yes, please list: _____

Seasonal Allergies: Yes _____ No _____

If Yes, please explain: _____

Bee Sting/Insect Bites: Yes _____ No _____

If Yes, list medication needed for allergic reaction: _____

Food Allergies: Yes _____ No _____

If Yes, which foods? _____

Type of reaction? _____

Type of medication needed for reaction? _____

Asthma: Yes _____ No _____

If Yes, frequency of attacks? _____

Known triggers? _____

Current daily asthma medications? _____

Normal Peak Flow _____

HEART DISEASE/HEART MURMUR: Yes _____ No _____

If Yes, any limitations in activity? _____

Please note: A doctor's note is required stating there is no limitation of activity to participate in gym, sports, or recess.

KIDNEY DISEASE: Yes _____ No _____

If Yes, please list: _____

DIABETES: Yes _____ No _____

If Yes, we will discuss and formulate careplan for the school year.

SEIZURES: Yes ____ No ____

Medications/Limitations: _____

Date of last seizure: _____ Type of seizure: _____

If current seizure disorder, we will meet and formulate careplan for the school year.

LYME DISEASE: Yes ____ No ____

If Yes, date of diagnosis: _____ Current medications/limitations? _____

GLASSES: Yes ____ No ____

If Yes, when are they to be worn? _____

HEARING DIFFICULTIES: Yes ____ No ____

If Yes, we please explain: _____

FREQUENT EAR INFECTIONS: Yes ____ No ____

If Yes, approximately how many infections and what age(s)? _____

FREQUENT STREP INFECTIONS: Yes ____ No ____

History of any of the following?

HEAD INJURIES: Yes ____ No ____

BROKEN BONES: Yes ____ No ____

HOSPITALIZATIONS: Yes ____ No ____

SURGERIES: Yes ____ No ____

If you answered Yes to any of the above, please give dates and explain: _____

Please list any other disabilities, limitations, or health concerns: _____

Previous School Attended: _____ Phone: _____

Parent Signature: _____ Date: _____

Revised March 2008

CR\Forms\Elem Health Questionnaire

PERMISSION SLIP

Please print:

Student's Name: _____ Sex _____ DOB _____ School: _____

Address: _____ Grade/Homeroom: _____

Home Phone: _____

Strep Test Date (Result + or -) Rx (Y or N) Urine Date Result Strep Type

(#155)

Dear Parent/Guardian:

Streptococcal infections of the throat can be followed by RHEUMATIC FEVER which is one of the important causes of heart disease in children. Rheumatic Fever may be preventable if one is treated for a strep infection.

The diagnosis of a strep throat is most reliably made with a throat culture. In the Toms River School District a quick strep antibody test is done as a free service.

Your child may have this test done in the nurse's office if he/she complains of a red, sore throat.

To help protect your child's heart, please sign below if you wish to have your child tested in school.

The school nurse has my permission to obtain a rapid strep test on my child as part of the Strep Disease Control Program of his/her school, as long as he/she is enrolled in this school system.

Has this child ever had Rheumatic Fever? Yes _____ No _____

Please note that your child should still be seen by the pediatrician if symptoms persist even if the result of the strep test is negative.

Signature: _____

Date: _____

Revised: 12/96