# TOMS RIVER REGIONAL SCHOOLS

## Health Office-New Entrance Questionnaire

Student Name:_____ DOB:_____ Date_____

Birthplace:_____ Age:_____ Sex:_____ Grade:_____

**PLEASE ANSWER THE FOLLOWING QUESTIONS AND EXPLAIN ANY "YES" ANSWERS IN THE SPACES PROVIDED**

**********

**MEDICATIONS:** Taken Daily? ▫ **YES** ▫ **NO** **If YES**, List names and doses:_____

_____

Medication required during school hours? ▫ **YES** ▫ **NO** **If YES**, Please see Nurse for instructions

**********

**ALLERGIES:** Life threatening? ▫ **YES** ▫ **NO** Medication Required? ▫ **YES** ▫ **NO**

**If YES,** Please see Nurse for Instructions

Medication type: ▫ **EpiPen** ▫ **Benadryl** ▫**Other**_____

**ALLERGY TYPE:** ▫ **Insect Sting/Bite** ▫ **Food** ▫ **Medication** ▫ **Seasonal** ▫ **Other**

**Specify Allergy Name/Type of reaction:** _____/_____

_____/_____

_____/_____

_____/_____

**ASTHMA:** ▫ **YES** ▫ **NO** ▫ **SEASONAL** ▫ **WEATHER RELATED** ▫ **ILLNESS RELATED**

**Known triggers:** _____

**Frequency of attacks (estimated):**

▫ **REGULARLY (1-2x a week)** ▫ **Occasionally (1-2x a month)** ▫ **RARELY (1-2x a year)**

**Current Daily Asthma Medications:**_____

**See Nurse if Medication will be required to be kept in school*

**HEART DISEASE:** ▫ **YES** ▫ **NO** **Heart Murmur:** ▫ **YES** ▫ **NO** **Diagnosed by a Doctor?** ▫ **YES** ▫ **NO**

Specify type of condition: _____

***PLEASE NOTE:*** *Child will not be permitted to participate in Gym, Health or Recess without a Cardiac Clearance Note from Physician. See Nurse for further instructions.*

**DIABETES:** ▫ **YES** ▫ **NO** **If YES,** *We will discuss and formulate a care plan for the school year.*

**SEIZURE DISORDER:** ▫ **YES** ▫ **NO** **FEBRILE EPISODES** ▫ **OTHER** **Diagnosed by a Doctor?** ▫ **YES** ▫ **NO**

Specify _____

**If YES,** *We will discuss and formulate a care plan for the school year.*

Medications / Limitations: _____

**Date of Last Seizure:** _____ Type: _____

**Other Neurological Disorder:** ▫ **YES** ▫ **NO** **Diagnosed by a Doctor?** ▫ **YES** ▫ **NO**

Specify type of condition:_____

**KIDNEY DISEASE:** ▫ **YES** ▫ **NO** Specify type of condition:_____

**LYME Disease:** ▫ **YES** ▫ **NO** **If YES, Diagnosis Date**_____

**Medications / Limitations**_____/_____

**HEALTH OFFICE NEW ENTRANT QUESTIONNAIRE: Continued**

**EYES:** ▫ **GLASSES** ▫ **CONTACTS** ▫ **BOTH** ▫ **ALL THE TIME** ▫ **AS NEEDED**

Disorder (Specify): _____ Last eye exam_____

**NOSE:** ▫ **NOSE BLEEDS** ▫ **NASAL DISCHARGE** ▫ **SINUS INFECTIONS** ▫ **FREQUENT** ▫ **OCCASIONAL**

**EARS:** **HEARING DIFFICULTIES** ▫ **YES** ▫ **NO** ***If YES:*** **HEARING AID** ▫ **YES** ▫ **NO**

**AUDITORY PROCESSING DISORDER** ▫ **YES** ▫ **NO**

**FREQUENT EAR INFECTIONS** ▫ **YES** ▫ **NO** **If YES, how many and what age(s)?**_____

**MOUTH / THROAT:** ▫ **DENTAL CAVITIES** ▫ **FREQUENT STREP INFECTIONS** ▫ **ENLARGED TONSILS**

Other concerns_____

**History of any of the following (check all that apply, give dates and explain below):**

▫ **HEAD INJURIES** ▫ **BROKEN BONES** ▫ **HOSPITALIZATIONS** ▫ **SURGERIES**

_____/_____

_____/_____

**********

**Please check any of the following *diagnosed or under evaluation by a physician*, and provide supporting medical documentation.**

▫ **AUTISM / ASD / Asperger's Syndrome** ▫ **ADD / ADHD** ▫ **Anxiety Disorder / OCD**
▫ **Disruptive Behavioral Disorder** ▫ **Dissociative Disorder**
▫ **BEHAVIORAL / EMOTIONAL DISORDER** ▫ **Pervasive Developmental Disorder**
▫ **MOOD DISORDER**

**LEARNING DISORDER:** ▫ ***Dyslexia*** ▫ ***Dyscalculia*** ▫ ***Dysgraphia*** ▫ ***Oral / Written Language Disorder*** ▫

***Non-Verbal Learning Disabilities*** ▫ ***Dyspraxia*** ▫ ***Executive Function*** ▫ ***Apraxia*** ▫ ***Speech Disorder***

**Other Learning Disorder:**_____

**********

**Please list any other disabilities, limitations or health concerns not already addressed or check ▫ N/A:**

_____

_____

**********

**PREVIOUS SCHOOL ATTENDED- Name**_____

**Address**_____

**Phone**____(_____)_____-_____ **Last Date Attended:**_____

**Parent Signature:**_____ **Date:**_____

**Does this child have any health insurance, including NJ Family Care / Medicaid, Medicare, private or other?**

▫ **YES Name of Insurance Company**_____ ▫ **NO, but you may release my name and address to the NJ FamilyCare Program to contact me about health insurance.**

**Signature:**_____**Printed Name:**_____**Date:**_____

*Written consent required pursuant to 20 U.S.C. & 1232g (b)(1) and 34 C.F.R. 99.30 (b)*

***NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information, call 1-800-701-0710 or visit www.njfamilycare.org to apply online.**

Revised 5/2020

# 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 Attached<br>☐ Date Next Immunization Due: |
|---|---|

### MEDICAL CONDITIONS

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

# Instructions for Completing the Universal Child Health Record (CH-14)

## Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

## Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860.
   - The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

# TOMS RIVER REGIONAL SCHOOLS

*1144 Hooper Avenue, Toms River, NJ 08753*

732-505-5000


## IMMUNIZATION REQUIREMENTS

Dear Parent/Guardian:

At the time of registration, please submit proof of the following information to the Health Office.

1. **Physical Examination Record:** A physical must be provided to your child's school prior to starting school. You are encouraged to go to your "**medical home**" (private MD) to complete the physical.
2. **Immunization Record** consisting of dates of Primary Series and booster doses. **N.J.S.S.C. Chapter 14** requires that immunizations must be complete and up-to-date, otherwise, the student may be excluded from school.

**DPT: Diphtheria and Tetanus Toxoids and Pertussis (DTP) Vaccine**

a. **FOUR (4)** doses for children less than 7 years of age. One does must have been administered on or after the fourth birthday....Or any 5 doses.
b. **THREE (3)** doses for children 7 years of age or older.
c. **Tdap:** Required on all sixth grade students born on or after January 1, 1997, effective September 1, 2008.

**Polio Virus Vaccine**

a. **THREE (3)** doses for those children less than 7 years of age, OPV or enhanced IPV is required provided at least one dose is given on or after the fourth birthday... or any doses.
b. **THREE (3)** doses for children 7-17 years, OPV or IPV will satisfy the polio vaccine requirement.

**Measles Vaccine**

a. **TWO (2)** doses of a measles-containing vaccine given on or after the first birthday. (Preschool requires a minimum of one (1) dose.

**Rubella Vaccine: Mumps Vaccine**

a. **ONE (1)** dose rubella and mumps vaccine administered on or after the first birthday

**Hepatitis B Vaccine – Kindergarten through Grade 12**

a. Appropriate 2 or 3 dose Hepatitis Vaccine, or laboratory evidence of immunity

**Varicella (Chicken Pox) Vaccine**

a. **ONE (1)** dose after the first birthday is required starting September 2004 for all pre-school, kindergarten and grade one students...OR...
b. Statement of past history of chicken pox or laboratory evidence of immunity is required for all students born after January 1, 1998.

**Meningococcal Vaccine**

a. **ONE (1)** dose required on all sixth grade students born on or after January 1, 1997, effective September 1, 2008.

**PRE-SCHOOL ONLY**

**Haemophilus Influenzae B (HIB)** – **ONE (1)** dose required after first (1st) birthday
**Pneumococcal** – Minimum **ONE (1)** dose after first (1st) birthday
**Flu (Influenza) Vaccine** – **ONE (1)** dose annually between September 1 and December 31

a. **Mantoux Tuberculine Test:** Required ONLY on those students entering the Toms River Regional School System coming directly from a high TB incidence country, according to the most current NJ State guideline.

**Students entering this district are REQUIRED to provide appropriate immunization records prior to entry.**