FY-09

STATE OF NEW JERSEY
HEALTH HISTORY AND APPRAISAL

IMMUNIZATION REGISTRY NUMBER

Name of Child (Last, First, M.I.) | Date of Birth (Mo/Day/Yr) | Sex ☐ Male ☐ Female

PARENT OR GUARDIAN NAME | TELEPHONE NO.

ADDRESS

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
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination ** (If Td or DT, indicate in corner box)*					
Tdap					
POLIO – INACTIVATED POLIO VACCINE (IPV) *If oral vaccine, indicate (OPV) in corner box*					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB)**					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE **					
MENINGOCOCCAL					
HEPATITIS A ***					
HPV (HUMAN PAPILLOMAVIRUS) ***					
OTHER					

LEAD SCREENING	
Test Date	Result

Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

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

HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR
ALLERGIES		DRUG ALLERGIES		NEUROMUSC. DISORDER		AUTISM SPECTRUM DISORDERS	
ASTHMA		HEART DISEASE		CHRONIC OTITIS MEDIA		HEMATOLOGICAL DISORDERS	
CONGENITAL DISORDER		HEPATITIS		AUTO IMMUNE DISORDERS		**OPERATIONS OR INJURIES**	
CONVULSIVE DISORDER		LYME DISEASE		STREP INFECTIONS			
DIABETES		MONONUCLEOSIS		JUVENILE RHEUMATOID ARTHRITIS			

HEALTH SCREENING CODE: N = Normal; R = Referred; T = Under Treatment; C = See Comments

Grade/Age																
Date																
Height																
Weight																
Blood Pressure																
VISION – With correction – R																
VISION – With correction – L																
VISION – With correction – BOTH																
VISION – Without correction – R																
VISION – Without correction – L																
VISION – Without correction – BOTH																
VISION – Muscle Balance																
HEARING – Date																
HEARING – Sweep Check – R																
HEARING – Sweep Check – L																

Color Perception Date Results

BIENNIAL SCOLIOSIS SCREENING (Beginning at Age 10) Referred for abnormal result

Date	Date	Date	Date	Date
_____	_____	_____	_____	_____
☐	☐	☐	☐	☐

TB Screening (Mantoux Test)

	Date	Date
Tested	_____	_____
Read	_____	_____
Result (MM)	_____	_____

Chest X-Ray

Date	Result: Normal	Result: Abnormal
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication
Reactor No Rx ☐
Date Started _____
Date Completed _____

*REQUIRES MEDICAL EXEMPTION **REQUIRED FOR DAY/CHILD CARE ENROLLEES (2 Months-5th Birthday Only) ***Not Required

E92-08302a

PHYSICAL EXAMINATIONS

Date	Grade/Age	Type of Exam	Significant Findings	Medical Provider

Date	RECORD: Findings and Recommendations of Physicians; Modification of School Program; Referrals and Follow-up; Conference with Parents, Teachers; Counseling with Student. Individual Nurses notes must be attached.	SIGNATURE