PRESCHOOL HEALTH REQUIREMENTS

Dates must be provided and signed by your physician and attached to the physical exam prior to your child being permitted to enter school. (The exception being the influenza vaccination, to be submitted between September 1 and December 15).

1	DTaP/DTP	Four (4) doses of DTaP/DPT
2	Polio	Three (3) doses of Polio vaccine
3	Measles	One (1) dose of a Measles containing vaccine given on or after the 1st birthday (preferable MMR)
4	Mumps	One (1) Mumps vaccine given on or after the 1st birthday (Part of MMR)
5	Rubella	One (1) Rubella vaccine given on or after the 1st birthday (Part of MMR)
6	Hib	One (1) dose of Haemophilis B vaccine (DTP/Hib and Hib/Hep B also valid Hib doses) after the age of one year (Usually have three)
7	Varicella	One (1) varicella (Chicken Pox) vaccine given on or after the 1st birthday.
8	Hepatitis B	Required for entrance to Kindergarten
9	Influenza	One vaccination is required between September 1 and December 15, of that year for all Preschool students age six months to 59 months.
10	Pneumocccal conjugate vaccine	One dose of PCV on or after their first birthday.
11	Recent Physical	Certifying your child's health status *done within one (1) year of the student's actual start date into the school (not the registration date into the program)*. ***Physical must be done on the Universal Child Health Record.***

In compliance with N.J.A.C. 18A:40-4, each student must obtain a physical examination upon entry in school. This examination must be done no more that 365 days prior to entry and must state what, if any, modifications are required for full participation in the school program.

Chapter 14 NJ State Sanitary Code N.J.A.C.8:57-4.2 Proof of Immunization-a principal, director or other person in charge of a school, preschool, or child care facility shall not knowingly admit or retain any child whose parent or guardian has not submitted acceptable evidence of the child's immunization, according to the schedules specified in this subchapter.

Revised 20/21

MEDICATION POLICY

Effective August 7, 1995, Roxbury Township Board of Education has revised policy #5330 regarding the administration of medication to students. According to the policy, “medication” means any prescribed or over-the-counter medicine. This also includes such medication as Tylenol, aspirin, or coach drops.

The following guidelines **must** be followed when the administration of medication in school is necessary:

1. The parent or guardian **and** private physician must provide a written request for the administration of the prescribed medication at school.
   The Physician’s written order must include the following:
   a. Diagnosis or type of illness involved
   b. Name of the medication
   c. Dosage
   d. Time of administration
   e. Time when its use will be discontinued
   f. Side effects

2. Currently dated **medication must be brought to the Health Office by the parent/guardian in the original labeled container**. (Most pharmacies will provide you with an extra bottle properly labeled for school.)

3. Medication no longer required must be promptly removed by the parent/guardian.

4. The school nurse or parent/guardian are the only persons to administer medication in school. Students with asthma or other potentially life threatening illness will be allowed to self-administer medication when a nurse is not physically present at the scene. Permission for such administration must be on file in the office of the school nurse and comply with the conditions for granting permission.

Medication permission slips may be obtained from your school nurse.

UNIVERSAL
CHILD HEALTH RECORD

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

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 ❑ Date Next Immunization Due _____

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	

Kennedy School Medication Administration Daily Log (to be completed for each medication)

School Year _____

Name of Student _____ Date of Birth _____ Sex _____ Grade/Teacher_____

**** Parent signature granting permission for administration of medication*** _____ ***Date*** _____

Name and Dosage of Medication _____ Route _____ Time(s) Given in School _____

Start date _____ End date _____ **(Medication must be in the original container as dispensed by the pharmacy or physician)**

Reason for medication _____

**** Physician signature*** _____ ***Date*** _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30 31
Sept																														
Oct																														
Nov																														
Dec																														
Jan																														
Feb																														
Mar																														
Apr																														
May																														
June																														

INITIAL SIGNATURE
(of person administering medication)

1. _____ _____ _____

2. _____ _____ _____

3. _____ _____ _____

4. _____ _____ _____

CODES*

(A) Absent

(E) Early Dismissal

(F) Field Trip

(N) No Medication Available

(O) No Show

(W) Dosage Withheld

(X) No School
(e.g., holiday, weekend, snow day, etc.)

*** See reverse side for reporting significant information.**