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

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

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ALLERGIES | | DRUG ALLERGIES | | NEUROMUSC. DISORDER | | AUTISM SPECTRUM DISORDERS | |
| ASTHMA | | HEART DISEASE | | CHRONIC OTITIS MEDIA | | HEMATOLOGICAL DISORDERS | |
| CONGENITAL DISORDER | | HEPATITIS | | AUTO IMMUNE DISORDERS | | | |
| CONVULSIVE DISORDER | | LYME DISEASE | | STREP INFECTIONS | | | |
| DIABETES | | MONONUCLEOSIS | | JUVENILE RHEUMATOID ARTHRITIS | | | |

| TB Screening (Mantoux Test) | Date | Date | Date | Chest X-Ray Date | Result Normal | Abnormal |
|---|---|---|---|---|---|---|
| Tested | | | | | | |
| Read | | | | | | |
| Result (MM) | | | | | | |

Therapy: Case ☐ Reactor ☐

Date Started ____________

Date Completed ____________

## Physical Examination

Tonsils: Diseased ______ Enlarged ______

Glands ____________

Heart ____________

Lungs ____________

Abdomen: Hernia ______ Genitals ______

Nose/Throat ____________

Ears ____________

Skeletal ____________

HT. ______ WT. ______ BP. ______ HEARING ______

VISION R 20/ ______ L 20/ ______ CORRECTED Y N

Is there any reason why this student should not participate fully in the physical education program? ☐ Yes ☐ No

If yes, explain ____________

COMMENTS: ____________

____________

____________
*Examining Physician's Signature*

*Doctor's Stamp Here*

____________
*Date*