

DIVINE MERCY ACADEMY IMMUNIZATION REQUIREMENTS

School immunization laws are one of the most effective tools for preventing outbreaks of contagious diseases in schools and communities. New Jersey State Law requires that all school children be vaccinated against certain vaccine-preventable diseases. Every school is required to maintain a record of immunization for each child enrolled.

Please note that in addition to age appropriate immunization requirements:

All children up to age 59 months entering Pre-School during the 2018-2019 school year are required to have a flu shot. The influenza vaccine must be given between September 1 and December 31 of each year. Students who have not received the flu vaccine by December 31 will not be allowed to attend Pre-School for the duration of the flu season (through March 31).

All Kindergarten children must submit proof of all required immunizations **prior** to the start of the school year.

All students entering grade 6, who are 11 years of age or older, are required by state law to have both Tdap and a Meningococcal vaccine. Proof of vaccination is **mandatory** for these students.

Routine medical exams or physicals of children are very important and are recommended at least once during each development stage, at early childhood (pre-school through grade 3), preadolescence (grade 4 through 6) and adolescence (grade 7 through 12).

Enclosed for your convenience is a Universal Child Health Record form for your physician to use at your next appointment. Please submit the completed form, along with immunization records to the school office.

Thank you for your cooperation.

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>			
Signature/Date _____		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER			
Date of Physical Examination: _____		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____
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MEDICAL CONDITIONS		
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> 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: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

<input type="checkbox"/> <i>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.</i>	
Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	