KEARNY SCHOOLS MEDICAL DEPARTMENT

MEDICAL REGISTRATION PACKET INSTRUCTIONS

Dear Parent/Guardian,

The following medical forms must be completed and provided at the time of registration at your child's assigned school:

1. ***Parental Screening Questionnaire***: To be completed by Parent/Guardian
2. ***Immunization Record***: To be completed by Physician
3. ***Physical Examination Form***: To be completed by Physician
4. ***Tuberculosis test results***: TB skin test or QuantiFERON-TB required for students born in some countries outside the US. Please consult your doctor if born outside of US. BCG is not accepted

Please be sure to have one completed medical packet for each child you are registering.

If you have any questions regarding the medical packet, please contact the nurse at your assigned school.

Los siguientes formularios médicos deben ser completados y entregados en el momento de la registración de su hijo(a) en la escuela asignada:

1. ***Parental Screening Questionnaire***- Cuestionario de información de los padres: Esto debe ser completado por el padre/representante del niño(a)
2. ***Immunization Record***- *registro de vacunas*: Esto debe ser completado por un doctor/médico.
3. ***Physical Examination Form***- *Formulario de Examen Físico:* Esto debe ser completado por un doctor/médico.
4. ***Resultados de la prueba de tuberculosis***- prueba cutánea de TB o QuantiFERON-TB requerido para estudiantes nacidos en algunos países fuera de los EE. UU. Consulte a su médico si nació fuera de EE. UU. BCG no se acepta

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Os seguintes formulários médicos devem ser preenchidos e entregues no dia da matrícula do seu filho na escola que lhe foi atribuida:

1. ***Parental Screening Questionnaire***- Questionário de Informação dos Pais: Este deve ser preenchido pelos pais/encarregados de educação do aluno.
2. ***Immunization Record***- Registro das Vacinas: Este deve ser preenchido por um médico.
3. ***Formulário de Exame Físico*** - Formulário de Exame Físico: Deve ser preenchido por um médico / médico.
4. ***Resultados do teste de tuberculose: teste cutâneo de TB ou QuantiFERON-TB necessário para alunos nascidos em alguns países fora dos EUA. Consulte seu médico se você nasceu fora dos EUA. BCG não é aceitoPhysical Examination Form***- Formulário do Exame Físico: Este deve ser preenchido por um médico.

KEARNY PUBLIC SCHOOLS MEDICAL DEPARTMENT

Parental Screening Questionnaire

Student Name: ______________________________ **Date of Birth:** ________________

PREGNANCY

FULL TERM ________
PREMATURE ________
DELIVERY METHOD ________
BIRTH WEIGHT ________
COMPLICATIONS ________

NEWBORN

COMPLICATIONS ________
____
RETAINED IN HOSPITAL
____
SURGERY ______________

DEVELOPMENTAL

MILESTONES MET APPROPRIATELYSPECIFY: _____

ANY CONCERNS __________
____

MEDICAL HISTORY

CURRENT MEDICATION
____
____

HOSPITALIZATIONS

DATES: ______________
REASON ______________

ALLERGIES

PEANUTS ________
*Anaphylaxis ________
SEASONAL ________
MEDICATION ________
FOOD ________

ASTHMA

MEDICATION PRESCRIBED
____
MOST RECENT ATTACK
____

HEARING/EAR ISSUES

SPECIFY: ______________

VISION/EYE ISSUES

SPECIFY: ______________

GASTROINTESTINAL ISSUES

SPECIFY: ______________

URINARY ISSUES

SPECIFY: ______________

DERMATOLOGY/SKIN ISSUES

SPECIFY: ______________

REVISED 03/25/14

KEARNY PUBLIC SCHOOLS MEDICAL DEPARTMENT

Immunization Record

Dear Parent/Guardian,

Please make sure your child's required immunizations are up to date. If your child's records are in a language other than English, please have your doctor translate those records utilizing this form.

Child's Name ______________________________ **Birth Date** ____________________

DPT/DT: *Pre K-12* 4 doses (4th dose on or after 4th birthday)

__________ __________ __________ __________ __________

1st 2nd 3rd 4th 5th

Tdap: *entering grade 6 born on or after 1/1/97* __________

IVP: *Pre K-12* 3 doses (3rd dose on or after 4th birthday)

__________ __________ __________ __________

1st 2nd 3rd 4th

MMR: *K-12* Measles: 2 doses (1st dose on or after 1st birthday)

Mumps/Rubella (1 dose)

__________ __________ Measles only __________

1st 2nd

Hepatitis B: *K-12* 3 doses (*4 if needed) / 2 adult doses (*last dose must be 6 months after 1st dose)

__________ __________ __________ __________

1st 2nd 3rd *4th (if needed)

Varicella: *Born on or after 1/1/98* 1 dose __________

HIB: *Pre K only* 1 dose **after 1 year old** __________

Pneumococcal Conj.: *Pre K only* 1 dose **after 1 year old** __________

Meningococcal: *entering grade 6 born on or after 1/1/97* __________

****PPD/TB TEST** **Required if born in high incidence country(BCG is not accepted)** __________
Result: __________

Date __________ **MD Signature** __________ **Stamp** __________

Revised 03/02/14

KEARNY PUBLIC SCHOOLS

ENTRANCE PHYSICAL EXAMINATION FORM

Student's Name ______________________________ Age ____________

Height ______________ Weight ______________ Blood Pressure ________________

Vision: Right _________ Left _________ Glasses (Yes/No) To be worn for ___________

Hearing: Right __________ Left__________

Scoliosis Exam _____________________ Nervous System (reflexes) _______________

Heart _________________ Lungs__________________ Abdomen _______________

Ears __________________Throat __________________ Nasal Passages ____________

Skin __________________ Allergies: (Yes/NO) Type __________ Asthma ___________

Medication ____

Genitals _______________ Hernia _______________ Skeletal System _______________

History of Positive TB Reaction __________________ INH ___________CXR __________

Mantoux: Date planted _________ Results ________________(May be read in school)

Is there any condition or history that we should be aware of?

____

____

____

Any limitations for Physical Education?

____

____

______________ ______________________________________

Date of Exam Signature and Stamp of Physician

Revised 02/10/2017

Tuberculosis Testing Requirement

Tuberculosis testing is required of all entrants born outside of the USA in a country of high incidence. **BCG is not accepted.**

PPD Placement__________________________

PPD result/ date_________________________

MD signature __________________________ MD STAMP (REQUIRED)

QUANTEFERON-TB GOLD/ IGRA Test **(fill out or attach lab result)**

Date_________________________________

Result________________________________

MD signature____________________________ MD STAMP (REQUIRED)