KEARNY SCHOOLS MEDICAL DEPARTMENT

MEDICAL REGISTRATION PACKET INSTRUCTIONS

Dear Parent/Guardian,

The following 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

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.

Thank you.

Estimado Padre/Representante,

Los siguientes formularios 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.

Por favor, asegúrese de completar un paquete médico por cada niño que está registrando.

Si tiene alguna pregunta relacionada al paquete médico, por favor comuníquese con la enfermera de la escuela que le fue asignada.

Gracias.

Estimados Pais/Encarregados de Educação,

Os seguintes formulários 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. ***Physical Examination Form-*** Formulário do Exame Físico: Este deve ser preenchido por um médico.

Por favor, certifique-se que tem o pacote completo para cada aluno que está a matricular. Se tiver algumas perguntas sobre o pacote médico, por favor entre em contato com a enfermeira da escola que lhe foi atribuida.

Obrigada.

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 APPROPRIATELY SPECIFY: _____

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: _____

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 ***On or After 1st Birthday*** _____

Pneumococcal Conj.: *Pre K only* 1 dose ***On or After 1st Birthday*** _____

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

PPD: _____ **Result:** _____

Date _____ **MD Signature** _____ **Stamp** _____

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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

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