Saint Teresa
REGIONAL SCHOOL

Required Health Information for Kindergarten Students

Welcome to St. Teresa Regional School! In order to keep your child safe, healthy, and happy at school, and in accordance with the State of NJ Departments of Health and Education, please note that the following health information is MANDATORY AND REQUIRED BY LAW as all students must have up to date health information on file at school. We must have sufficient time to review your child's health information prior to their first day at school to assure that all information is up to date and so that we may be address any health-related needs your child may have. Therefore, if your child is starting school in September, these forms are required by August 1. If your child is starting school at any other time, these forms are required ASAP prior to their first day of school.

- ✓ **Immunization record*.** All immunizations must be up to date based on age. In addition, please note that ALL NJ pre-K students are required to receive the flu shot between September 1 and December 31 each year they attend pre-school.
- ✓ **A physical examination.** This must be recent (within one year) and must be completed/signed by your child's physician. You may send in a form generated by your physician, or you may choose to have your physician complete the attached form (if you use the St Teresa form, your physician may charge you to complete it).
- ✓ **Health history form.** This form is completed by a parent and helps us to better understand your child and any potential needs they may have.
- ✓ **Medication administration form.** Both the parent and physician complete this form if your child may require any medications during school hours. These include both prescription and over-the-counter medications such as Tylenol, Motrin, cough drops/syrup, etc.
    - o **Please tell us if your child requires an inhaler for use during school or has an Epi-pen/Epi-pen Jr. You will need to obtain an extra inhaler or Epi-Pen/Epi-pen Jr. to be kept at school, and there are additional forms required specific to these medications.**
- ✓ **Permission to screen form.**
- ✓ **Dental exam form.** This form must be completed by your child's dentist.

If you have any questions please feel free to call Mrs. Julie Kosylo, our school Nurse, at 856-939-0850, or the school office at 856-939-0333.

*Note that in NJ, all students attending public or private school must be immunized unless there is a documented valid medical or religious exemption on file at school.

27 EAST EVESHAM ROAD RUNNEMEDE, NEW JERSEY 08078

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Forming Minds and Hearts for Leadership and Service

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MEDICAL EXAMINATION FORM

CHILD'S NAME _____ DATE OF EXAM _____

B.P. _____ PULSE _____

HEIGHT _____ WEIGHT _____

SKIN _____

LYMPH SYSTEM _____ CERVICAL _____

AXILLARY _____ INGUINAL _____

HEAD AND NECK _____

EYES _____ EARS _____

NOSE _____ MOUTH _____

CHEST- HEART _____

LUNGS _____

EXTERNAL DEFORMITIES _____

ABDOMEN _____ GENITALIA _____

BACK AND SPINE _____

EXTREMITIES _____

NERVOUS SYSTEM (REFLEXES) _____

ANY SERIOUS OR CHRONIC ILLNESSES? _____

PREVIOUS SURGERIES? _____

REMARKS _____

IS CHILD ON ANY MEDICATIONS? YES _____ NO _____

IF YES, PLEASE EXPLAIN _____

SIGNATURE OF PHYSICIAN _____ DATE _____

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Health History

Child's Name	Birth date
Address	Telephone
Parents' Names	Current date
PERINATAL	
Child's birth weight	Length
Complications of Pregnancy	
Complications of Delivery	
Was the baby premature?	Breathing problems?
Feeding problems?	Congenital Defects?
Problems during the newborn period	Behavior during infancy?
DEVELOPMENTAL	
At what age did the child walk?	Talk?
Toilet trained?	Did your child wet the bed?
Suck his/ her thumb?	Hand preference?
MEDICAL HISTORY	
Has your child had any vision problems?	Frequent ear infections?
Respiratory problems?	Seizures?
Speech difficulties?	Heart murmurs?
Orthopedic problems?	Operations?
Illnesses?	Accidents?
Allergies?	Medications?
Restrictions on physical activity?	
Has your child been tested for lead poisoning?	No_____ Yes_____ Level _____
FAMILY	
The child is # _____ of _____ children	Chronic diseases in family?
Recent changes in family life?	
Other:	

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School Health Program
Permission for School Health Services

Student Name _____ Grade _____

This permission form allows your child to participate in the school health screening program. It will stay with your child from Kindergarten through 8th grade, and will be incorporated into your child's school health record.

I hereby give permission for my child to receive the following medical screenings as part of the general school health program, as recommended by Camden County Health Services and the State of New Jersey.

- ✓ Annual height and weight (all grades)
- ✓ Blood pressure (all grades)
- ✓ Vision screening (pre-K, K, 2, 4, 6, 8)
- ✓ Hearing screening (pre-K, K through 4, 6, 8)
- ✓ Scoliosis screening* (grades 4, 6, 8)

*Scoliosis is a lateral curvature of the spine most commonly found during the adolescent growth period.

You will be notified before the scoliosis screening and may with draw permission for any screening procedure at any time.

No medical information will be shared with other school personnel unless requested by the parent/guardian or is necessary for your child's safety and well-being.

Parent/Guardian Signature _____

(rev. 11/2012)

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Dear Parent or Guardian:

Please have your family Dentist complete and sign the bottom portion of this form as soon as possible.

Julie Kosylo, R.N.
School Nurse

Date of exam:

Name:

Age:

_____ Has been examined and is receiving treatment.

_____ Treatment has been completed.

_____ No treatment necessary at this time.

_____
Dentist's Signature/Date

Comments:

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MEDICATION ADMINISTRATION FORM

This form must be completed by BOTH the physician and the parent, regardless of whether the medication is over-the-counter or prescription. (Inhalers and Epi-pen/Epi-pen Jr. require different forms. Please obtain these forms from the school nurse.)

Child's Name_____ Date of Birth_____

Medication_____

Diagnosis/Indication_____

Dosage and Schedule_____

Route of Administration_____

Effective Dates: _____Current School Year

_____From _____ to _____ only.

Physician's Signature_____ Date_____

Parent's Signature_____ Date_____

Medication_____

Diagnosis/Indication_____

Dosage and Schedule_____

Route of Administration_____

Effective Dates: _____Current School Year

_____From _____ to _____ only.

Physician's Signature_____ Date_____

Parent's Signature_____ Date_____

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