St. Cassian School
190 Lorraine Ave. Upper Montclair, NJ 07043
Tel: 973-746-1636 Fax: 973-746-3271
www.stcassianschool.org

Non-Public School Health Services Immunization Requirements

For School Attendance in New Jersey

The New Jersey Department of Health and Human Services makes available the law that states which vaccines a child needs to attend school in New Jersey. As per New Jersey Administrative Code (N.J.A.C.) 8:57-4: IMMUNIZATION OF PUPILS IN SCHOOL; REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY below is listed, according to age/grade, the vaccines required.

Pre-K

Dtap = minimum of 4 doses
Polio (IVP) = minimum of 3 doses
MMR = 1 dose given on or after the 1st birthday
HiB = minimum of 1 dose given on or after the 1st birthday
Pneumococcal Conjugate (PCV) = minimum of 1 dose given on or after the 1st birthday
Varicella = 1 dose given on or after the 1st birthday or parental/health care provider statement of previous chicken pox disease or laboratory evidence of immunity
Influenza = 1 seasonal dose given annually between September 1st through December 31st

Kindergarten

Dtap = minimum of 4 doses, with 4th dose given on or after the 4th birthday OR any 5 doses properly spaced Polio (IVP) = minimum of 3 doses, with 3rd dose given on or after 4th birthday OR any 4 doses properly spaced MMR = 2 doses given on or after 1st birthday and properly spaced OR laboratory evidence of immunity in lieu of dose 2
Varicella = same as above (the ACIP is presently recommending that a 2nd dose be given at age 4 as a booster) HIB = not required after age 5
Pneumococcal Conjugate (PCV) = not required after age 5
Hepatitis B = 3 dose series is required

Grades 1 - 5

All immunizations required as above.

Grade 6

All immunizations required as above
PLUS: Tdap = 1 dose by 11 years of age
Meningococcal Conjugate (MCV4) = 1 dose by 11 years of age

Grade 7 – 8

All immunizations required as above.

Any child born on or after January 1, 1997 and transferring into a New Jersey school from another state or country after September 1, 2008, must provide documentation of having received 1 dose of Tdap and Meningococcal Conjugate.
Any child transferring into a New Jersey school from another state or country may enter school provided they have received at least 1 dose of each required vaccine. They will have 1 year to complete each vaccine series. Unless already on file in the health office, documentation of these required immunizations must be submitted to the school nurse PRIOR to the child entering school/grade. Noncompliance will temporarily prevent school attendance until the vaccines are given and documentation submitted. Please keep the school nurse updated on any additional vaccines your child receives.

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HEALTH HISTORY AND PARENT'S CONSENT FORM

Pupil's Name_____ Date of Birth_____
Last First Month/Day/Year
Address:_____
Street City Zip
School _____Grade_____Room_____

Nurse_____

Dear Parent or Guardian:
The school physician or school nurse is authorized by the Division of Health to carry out the following procedures for your child provided you sign your name below and return this form to the school.

Principal's Signature_____

Dear Principal:
I hereby request that the above named child be provided posture inspections,*tuberculin test, and any other health procedure that is deemed necessary for the child's wellbeing. It is understood that the aforementioned child ;health services will be provided by a school physician or a school nurse and that I will be notified in advance before any other non-emergency test or procedure is to be conducted.

Signature of Parent or Guardian_____

Remarks:_____

_____

HEALTH HISTORY:

Is child currently taking any medicines?_____

Type of medicine_____

If yes, Please explain_____

DISEASE HISTORY	TYPE	YEAR	YEAR
Allergies	Asthma	Otitis Media	
Congenital Defects	Chicken Pox	Rheumatic Fever	
Drug Sensitivities	Convulsive Disorder	Strep Infections	
Hepatitis	Diabetes	Mononucleosis	
Neuromuscular Disorder	Heart Disease	Other	

OPERATIONS/INJURIES _____

_____

DATE:_____

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PHYSICAL EXAMINATION

NAME_____ **EXAM DATE**_____**AGE**_____**DOB**_____
ADDRESS_____**CITY, STATE, ZIP**_____**PHONE #**_____
SCHOOL_____**SPORT**_____**GRADE**_____**SEX**___
PHYSICIAN_____**PHONE**_____**FAX**_____
ADDRESS_____**CITY, STATE, ZIP**_____

PHYSICIAN OR PROVIDER INFORMATION

HEIGHT: _____**WEIGHT**_____**BLOOD PRESSURE** _____/_____ **PULSE**_____**BPM**
VISION: R 20/_____ **L 20/**_____ **CORRECTED: Y/N GLASSES: Y/N HEARING R**_____ **L**_____

	NORMAL	ABNORMAL FINDINGS	COMMENTS
Head/Neck			
Eyes/Sclera/Pupils			
Ears/Hearing			
Nose/Mouth/Throat			
Heart: Murmurs/Rhythms			
Lungs: Auscultation/Percussion			
Chest Contour			
Skin			
Abdomen: Assessment (incl. liver spleen)			
Tanner Stage: Testes/onset of menses			
Hernia	No	Yes/Possible	
Neck/Back/Spine: Range of Motion			
Scoliosis			
Upper Extremities			
Lower Extremities			
Neurological: Balance & coordination			
Romberg			
Heel walk			
Tandem walk			
Nose touch			
Toe walk			
Most recent immunization/ dates:			
Medications currently in use:			
Allergies:			
Other:			
Operations or accidents:			

A. **Students may participate in athletics: Yes**_____ **No**_____ **Date**_____
B. **Cleared after completing evaluation/rehabilitation for:**
C. **NOT CLEARED for: Collison** _____ **Contact** _____ **No-Contact**_____
Strenuous_____ **Moderate**_____ **Non-Strenuous**_____

Diagnosis: _____ **Recommendations:** _____
_____ _____

Examined by: Family Physician / Provider _____ **School Physician**_____
MD_____ **DO**_____ **NP**_____ **PA**_____

_____ **Physician/Provider Stamp:**
Physician/Provider Signature