HASBROUCK HEIGHTS PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

MEDICAL REQUIREMENTS FOR REGISTRATION

PARENTS - TODAY

1. Health History Questionnaire
2. Authorization Exchange Information
3. Health Screening Program Form
4. Request for Medical Transcript / A45

DOCTOR / DENTIST

1. Physical Evaluation Form **(must include hearing & vision)**
2. Immunization Form
3. Dental Form

HEALTH SERVICES

1. Hasbrouck Heights Board of Health Letter
2. Family Care
3. North Hudson Community Health Center – NJPCA
4. Bergen Volunteer Medical Initiative – BVMI
5. Dental Hygiene Clinic – Bergen Community College

Lincoln School
Kimberly Kane, RN
(201) 393-8184 office
(201) 393-0365 fax

HS/MS
Mary Neumann, RN
(201) 393-8160 office
(201) 393-8948 fax

Euclid School
Jolanta Czajkowski, RN
(201) 393-8178 office
(201) 288-0753

3/3/11 updated

HASBROUCK HEIGHTS PUBLIC SCHOOLS
PHYSICAL EVALUATION FORM

(PARENTS TO FILL OUT) **-STUDENT INFORMATION-**

Student's Name: _____ Sport: _____
Sex: M F (circle one) Age: _____ Grade: _____ Date of Birth: _____
Address: _____
City/State/Zip:_____ Home Phone: _____
School: _____ District: _____
Parent/Guardian's Full Name: _____

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH PAGES

Examination Date:
Name: _____ Phone: _____ Fax: _____

Address: _____ City/State/Zip:_____

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse:

Vision: R 20/____ L 20/ ____ Corrected: Y / N Contacts: Y / N Glasses: Y / N Hearing:R_____L_____

Indicators	**Normal? (Circle One)**		**Abnormal Findings/Comments**
Head/Neck	YES	NO	
Eyes/Sclera/Pupils	YES	NO	
Ears	YES	NO	
Nose/Mouth/Throat	YES	NO	
Heart: Murmurs/Rhythms	YES	NO	
Lungs: Auscultation/Percussion	YES	NO	
Chest Contour	YES	NO	
Skin	YES	NO	
Abdomen: Assessment (incl. liver, spleen)	YES	NO	
Tanner Stage: Testes/Onset of Menses:	YES	NO	
Neck/Back/Spine: Range of Motion:	YES YES	NO NO	
Scoliosis:	YES	NO	
Upper Extremities:	YES	NO	
Lower Extremities:	YES	NO	
Neurological: Balance & Coordination: Romberg:	 YES YES	 NO NO	
Heel Walk:	YES	NO	
Tandem Walk:	YES	NO	
Nose Touch:	YES	NO	
Toe Walk:	YES	NO	
Hernia? (if yes/possible, please explain)	YES/ Possible	NO	

Most recent immunizations/Dates:
Medications currently being used:
Additional Observations:

General Diagnosis: _____
Recommendations: _____

CLEARANCES

A. Student MAY participate in the following sports: (CHECK ALL THAT APPLY)

___ CONTACT/COLLISION
___ LIMITED CONTACT
___ NON-CONTACT/STRENUOUS
___ NON-CONTACT/NON-STRENUOUS

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	**Limited Contact**	**Non-Contact**	
		Strenuous	**Non-strenuous**
Field Hockey	Baseball	Discus	Bowling
Football	Basketball	Javelin	Golf
Ice Hockey	Cheerleading	Shot put	
Lacrosse	Diving	Rowing	
Soccer	Fencing	Running/Cross Country	
Wrestling	Field	Strength Training	
	High Jump	Swimming	
	Pole vault	Tennis	
	Gymnastics	Track	
	Skiing		
	Softball		
	Volleyball		

B. Student MAY participate in following sport(s) ONLY AFTER completing evaluation/rehabilitation:(CHECK ALL THE APPLY)

___ CONTACT/COLLISION
___ LIMITED CONTACT
___ NON-CONTACT/STRENUOUS
___ NON-CONTACT/NON-STRENUOUS

Please specify each condition requiring clearance before participating in a sport in the classification checked above:

_____

_____

Conditions requiring clearance before sports participation include, but are not limited to: *Atlantoaxial instability; Bleeding disorder; Hypertension;Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.*

EXAMINED BY:
Family Physician/Provider_____
School Physician_____
____MD ____DO____NP____PA

Physician's/Provider's Stamp:

NOTE TO SCHOOL PHYSICIANS: Pursuant to N.J.A.C. 6A:16-2.2, the school physician shall provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this medical report. Please attach this form to the notification letter and ensure that this report is made part of the student's permanent health record.

HASBROUCK HEIGHTS PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES
Hasbrouck Heights, NJ, 07604

Name:_____ Date:_____

School:_____ DOB:_____ Grade:_____

Dear Parent / Guardian:

According to the New Jersey State Sanitary Code, Chapter 14: Administrative Code 8:57-4:17, no pupil may enter in a school who has not submitted acceptable evidence of immunization against disease to the School Health Office.

THE RECORD MUST CONTAIN THE NAME, ADDRESS & PHONE NUMBER OF THE PHYSICIAN

New Jersey Department of Health and Senior Services
STANDARD SCHOOL / CHILD CARE CENTER IMMUNIZATION RECORD

NAME OF CHILD (Last, First, MI)	DATE OF BIRTH (Mo./Day/Yr.)	SEX ☐M ☐F
NAME OF PARENT/GUARDIAN	TELEPHONE NUMBER(S)	
ADDRESS		
ADDRESS	IMMUNIZAITON REGISTRY NUMBER	

VACCINE TYPE	1ST DOSE MO/DAY/YR	2ND DOSE MO/DAY/YR	3RD DOSE MO/DAY/YR	4TH DOSE MO/DAY/YR	5TH DOSE MO/DAY/YR	LEAD SCREENING *(Not Required)* TEST DATE	RESULT
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT[1], indicate in corner box)							
POLIO-INACTIVATED POLIO VACCINE (IPV) (If oral vaccine, indicate OPV in corner box)							
MEASLES, MUMPS, RUBELLA (MMR)					[5] Document below single antigen vaccine receipt, serology titers, or varicella disease history		
HAEMOPHILUS B (HIB) [2]							
HEPATITIS B [3]					Hepatitis B	DATE:	TITER:
VARICELLA [4]					Varicella	DATE:	TITER:
PNEUMOCOCCAL CONJUGATE [2]					Measles	DATE:	TITER:
INFLUENZA [6]					Mumps	DATE:	TITER:
OTHER, SPECIFY:					Rubella	DATE:	TITER:

☐Provisional Admission Attached - Date Granted: _____ ☐Medical Exemption Attached ☐Religious Exemption Attached

[1] REQUIRES MEDICAL EXEMPTION.
[2] REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (2 Months - 5th Birthday Only)
[3] REQUIRED FOR K-GRADE 1 (whichever Is first). GRADE 6 BEGINNING 9-1-01, AND GRADES 9-12, EFFECTIVE 9-1-04.
[4] REQUIRED FOR DAY/CHILD CARE ENROLLEES (19 Months and older) AND GRADE K-GRADE 1 (whichever is first) EFFECTIVE 9-1-04.
[5] MMR single antigen receipt requires MO/DAY/YR, serologies require titers, and varicella disease history requires MO/YR.
[6] REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (6 Months – 59 Months)

HASBROUCK HEIGHTS PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES
Hasbrouck Heights, New Jersey 07604

Dental Visit Form

Student Name: _____ Date of Birth:_____

School:_____ Class/Grade:_____

The above named student was seen in this office on _____ for a dental exam. His/her teeth are:

____ In good health
____ In need of further treatment

_____ _____
Dentist's signature Telephone Number

_____
_____
_____
Address or stamp

HASBROUCK HEIGHTS PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

Health History Questionnaire

To the parents or guardians of _____

It is important we have this information for your child's well-being during his/her school hours. Please complete and return this form to the School Nurse as soon as possible.

1. Does he/she have a medical Problem? If yes, please state problem:

_____

_____

_____

_____

_____

2. Is he/she on medication? If yes, pleas list medication(s):

_____

_____

3. Are there any restrictions? If yes, please list restrictions:

_____

_____

4. Does your child have any allergies to food or medication? If yes, what:

_____

_____

This information will be shared with staff as necessary. If you DO NOT want this information shared, please notify me immediately. Thank you for your cooperation in this matter.

Parent Signature:_____ Date: _____

UPDATED 1/23/09

(PARENT)

Hasbrouck Heights Public School
School Health Services

AUTHORIZATION

FOR THE EXCHANGE OF CONFIDENTIAL INFORMATION

STUDENT_____ DATE OF BIRTH_____

As the parent/guardian of the above named student, I hereby authorize the release of pertinent medical information (medical conditions, allergies, medications and treatment regimes) to be exchanged among appropriate professional staff involved in the care of the above named student.

This consent is valid while your child attends school in the Hasbrouck Heights Public School and is intended to allow the staff to better serve your child. If you have any questions or concerns, please contact my office at the telephone number noted above.

_____ _____
Signature of Parent / Guardian Date

_____ _____
Print name of Parent / Guardian Telephone Number

Thank you,

The Nursing Department
Hasbrouck Heights Public School

updated 1/23/09