

Essex Fells School
102 Hawthorne Road
Essex Fells, NJ 07021
973-226-0505

Health Services Information
For Registration

All new students entering the Essex Fells School must have the following health-related documentation on record prior to his/her first day of school:

Pursuant to Title 8-Chapter 57, New Jersey Department of Health and Regulations require that all New Jersey pupils be immunized. No pupil will be admitted to school in our district without evidence of having been immunized by the following agents and a Certificate of Immunization History completed and signed by a licensed health care provider:

- Diphtheria Toxoid
- Pertussis Vaccine (Whooping Cough)
- Tetanus Toxoid
- Live Poliomyelitis Vaccine – Trivalent
- Live attenuated Measles Virus Vaccine and Measles Booster Vaccine
- Live Rubella Virus Vaccine (German Measles)
- Live Mumps Vaccine
- HIB Vaccine (required for all incoming kindergarten and pre-school students)
- Hepatitis B Vaccine
- Varicella Vaccine (Chicken Pox)
- Influenza (Flu Vaccine) (Required for all Preschool Students)

Pursuant to N.J.A.C. 6A:16-2.2, upon entering the school district each child must have an up-to-date physical examination and immunization record. This examination must have been completed by a licensed health care provider no more than 365 days prior to entering school. Please return this form to the school nurse. Failure to submit the Form could result in your child's exclusion from school.

*The Health Services Information packet should be brought to the School Nurse. However, if they are not yet completed, all forms must be provided no later than September 8. If your child was born between June 1 and October 1, please provide the most up to date immunization records by the end of the 1st week of school and provide the completed Student Medical Examination Form as soon as possible.

If you have any questions, please call the School Nurse, **Mrs. Mary Renz, MSN, RN, CSN** at **973-226-0505, Extension 208**.

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Student Medical Examination
(to be completed by a licensed health provider)

Student Name:						Date of Birth:				<input type="checkbox"/> Female <input type="checkbox"/> Male	
Home Address:											
School:						Grade:					
Growth and Development:											
		Normal				Premature				Term	
Complications											
Early illness or injury											
Systems Review:											
Height				Weight				Pulse			
Vision:		R		L		B		Glasses/Contacts			
Audio:		R		L		EENT				Speech	
Integument				Head & Neck				Lymphatic			
Respiratory				Cardiovascular				Abdomen			
Gastrointestinal				Genitourinary				Urinalysis			
Musculoskeletal				Hernia				Scoliosis			
Nervous				Emotional Symptoms				Nutrition			
Oral Health											
Neurological/Psychological:											
General Assessment:											
Allergies/Drug Sensitivities (Please list any special needs and/or medication required):											
Medical History and any other medical conditions:											
	Year		Year		Year		Year				
Lyme Disease		Asthma		Strep Infections		Operations/Injuries					
Seizure Disorder		Diabetes		Hospitalizations		Congenital Defects					
Other											
Last Dental Checkup and Treatments											

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(PLEASE USE PAGE 2 FOR IMMUNIZATION HISTORY)

Student Name: _____					DOB: _____	
Immunization History: (Please include month/day/year of vaccine)						
DTaP:		1. _____ mm/dd/yy	2. _____ mm/dd/yy	3. _____ mm/dd/yy	4. _____ mm/dd/yy	5. _____ mm/dd/yy Booster
Tdap: (for students born after January 1997 and students entering Grade 6)		_____ Booster				
Polio	IPV:	1. _____ mm/dd/yy	2. _____ mm/dd/yy	3. _____ mm/dd/yy	4. _____ mm/dd/yy	5. _____ mm/dd/yy
	OPV:	1. _____ mm/dd/yy	2. _____ mm/dd/yy	3. _____ mm/dd/yy	4. _____ mm/dd/yy	5. _____ mm/dd/yy
MMR:		1. _____ mm/dd/yy	2. _____ mm/dd/yy	3. _____ mm/dd/yy		
Measles:		1. _____ mm/dd/yy	2. _____ mm/dd/yy			
Mumps:		1. _____ mm/dd/yy	2. _____ mm/dd/yy	Varicella Zoster:		1. _____ mm/dd/yy 2. _____ mm/dd/yy
Rubella:		1. _____ mm/dd/yy	2. _____ mm/dd/yy			
HIB Vaccine:		1. _____ mm/dd/yy	2. _____ mm/dd/yy	3. _____ mm/dd/yy	4. _____ mm/dd/yy	5. _____ mm/dd/yy
Hepatitis A Vaccine:		1. _____ mm/dd/yy	2. _____ mm/dd/yy			
Hepatitis B Vaccine:		1. _____ mm/dd/yy	2. _____ mm/dd/yy	3. _____ mm/dd/yy		
PPD Mantoux: (TB)		Date Tested: _____	Date Read: _____	Results: _____		
Lead Test:		Date Tested: _____	Lead Level: _____			
Influenza Vaccine: (mandatory for pre-school students)		1. _____ mm/dd/yy	2. _____ mm/dd/yy	3. _____ mm/dd/yy	4. _____ mm/dd/yy	
Pneumococcal Vaccine: (mandatory for pre-school students)		1. _____ mm/dd/yy				
Meningococcal Vaccine: (mandatory for incoming Grade 6 students)		1. _____ mm/dd/yy	2. _____ mm/dd/yy	3. _____ mm/dd/yy		
Other (specify): _____						

Date of Examination: _____

Physician's Signature: _____