Livingston Public Schools
11 Foxcroft Drive - Livingston, New Jersey 07039

Health Services Information

All new students entering the Township of Livingston Public Schools must have the following health-related documentation on record **prior to his/her first day of school.** If registering for the next school year, please provide the completed Health Services Information packet at the time of your registration appointment.

Pursuant to Title 8-Chapter 57, New Jersey Department of Health and Regulations require that all New Jersey pupils be immunized with the following vaccines. **No pupil will be admitted to any 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:

Pre-school entrance requirements at Burnet Hill:
HIB vaccine - 3 required
Influenza vaccine – current
Pneumococcal – current
Diphtheria Pertussis Toxoid (DTaP) – 4 required
Poliomyelitis Vaccine (IPV/OPV) – 3 required
Measles, Mumps, Rubella Vaccine and Booster (MMR) – 1 required
Hepatitis B series – 3 required
Varicella Vaccine – 1 required

Elementary School requirements:
Diphtheria Pertussis Toxoid (DTaP) – 5 required
Poliomyelitis Vaccine (IPV/OPV) – 4 required
Measles, Mumps, Rubella Vaccine and Booster (MMR) – 2 required
Hepatitis B series – 3 required
Varicella Vaccine – 1 required

Mandatory for Entrance into grade 6:
Tdap Booster vaccine (for students born after 1997 as well)
Meningococcal Vaccine

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. This examination must have been completed by a licensed health care provider no more than 365 days prior to entering school. Failure to submit a Student Medical Information/Immunization Form could result in your child's exclusion from school.

Student Medical Examination/Immunization Record Form
Dental Form
Confidential Medical Information Form
Mantoux Tuberculin Notification Form (if applicable)

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Student Medical Examination/Immunization Record

(Form to be completed by a licensed health provider.)

Student Name: _____ Date of Birth: _____ ☐ Female ☐ Male

Home Address: _____

School: _____ Grade: _____

Growth and Development: Normal _____ Premature _____ Term _____

Complications _____

Early illness or injury _____

Systems Review:

Height _____ Weight _____ BMI _____ Blood Pressure _____

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 _____

Neurological/Psychological: _____

General Assessment: _____

Remarks (Please list any special needs and/or medication required.): _____

Medical History:

	Year		Year		Year		Year
Allergies		Asthma		Otitis Media		Operations/Injuries	
Drug Sensitivities		Chicken Pox		Rheumatic Fever			
Lyme Disease		Seizure Disorder		Strep Infections		Hospitalizations	
Hepatitis		Diabetes		Mononucleosis			
Neuromuscular Disease		Heart Disease		Other		Congenital Defects	

(Please use page 2 for immunization history.)

Immunization History

Student Name: _____

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*

Rubella: 1. _____ *mm/dd/yy* 2. _____ *mm/dd/yy*

Varicella Zoster: 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: Date Tested: _____ Date Read: _____ Results: _____

Influenza Vaccine:
(mandatory for pre-school students) 1. _____ *mm/dd/yy* 2. _____ *mm/dd/yy* 3. _____ *mm/dd/yy* 4. _____ *mm/dd/yy*

Pneumonoccal 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*

_____ *Date of Examination* _____ *Physician's Signature*

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Dental Form

(Form to be completed by dentist.)

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____

Name of Dentist: _____

Address of Dentist: _____

Dentist's Phone Number: _____ Dentist's FAX Number: _____

Date of Last Dental Exam: _____

Describe dental care student requires:

_____

_____

_____

_____

_____ _____

Signature of Dentist *Date*