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)
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:

<table>
<thead>
<tr>
<th></th>
<th>Year</th>
<th>Year</th>
<th>Year</th>
<th>Year</th>
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</thead>
<tbody>
<tr>
<td>Allergies</td>
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<td>Drug Sensitivities</td>
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<tr>
<td>Lyme Disease</td>
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<tr>
<td>Hepatitis</td>
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<tr>
<td>Neuromuscular Disease</td>
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<td></td>
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<tr>
<td>Asthma</td>
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</tr>
<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Seizure Disorder</td>
<td></td>
<td></td>
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<tr>
<td>Diabetes</td>
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<td>Heart Disease</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

(Please use page 2 for immunization history.)

Immunization History
<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Date 1</th>
<th>Date 2</th>
<th>Date 3</th>
<th>Date 4</th>
<th>Date 5</th>
<th>Booster</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td></td>
</tr>
<tr>
<td>Tdap (for students born after January 1997 and students entering Grade 6)</td>
<td>Booster</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPV</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td></td>
</tr>
<tr>
<td>OPV</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella Zoster</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIB Vaccine</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A Vaccine</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B Vaccine</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPD Mantoux</td>
<td>Date Tested:</td>
<td>Date Read:</td>
<td>Results:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza Vaccine</td>
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<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Vaccine</td>
<td>mm/dd/yy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal Vaccine</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td>mm/dd/yy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 ________________
## Confidential Medical Information Form
*Form to be completed by parent/guardian.*

_______________ School Year

<table>
<thead>
<tr>
<th>Student’s Name:</th>
<th>Grade:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Name:</td>
<td>Office Phone Number:</td>
</tr>
</tbody>
</table>

**Does your child take any medication regularly? If yes, Please List in the space provided below.**

- [ ]

**The school nurse has my permission to administer the following over-the-counter medications to my child during the school day (parents will be notified prior to the delivery of all medication):**

- [ ] Tylenol/Acetaminophen
- [ ] Advil/Motrin/Ibuprofen
- [ ] Tums
- [ ] Cough Drops

**Does/Did your child have any of the following? If YES, please give details below.**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

- **Allergies (seasonal, food, bee stings, medicine):** List allergens and types of reactions below. *(If an EpiPen is required, a “Physician’s Orders for Allergy Treatment” form must be printed from the school web page, filled out by the physician and submitted each school year.)*

- **Asthma (allergic, exercise induced):** Describe symptoms and treatment below. *(If an inhaler is necessary, an “Asthma Treatment plan” form must be printed from the school web page, filled out by the physician and submitted each school year.)*

- **Diabetes:**

- **Seizure Disorder:**

- **Hearing Difficulties:**

- **Eyeglasses/Contact Lenses:** *(If yes, when should they be worn?)*

- **Fainting with Exercise?**

- **Any previous joint disease, injuries, fractures?**

- **Loss of consciousness after injury?**

- **Heart problems, chest pain, palpitations, murmur?**

Page 1 of 2
Has your child ever been hospitalized? If YES, please list dates and detailed reasons below.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Surgery? If YES, please list dates and detailed reasons below.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Do you have any concerns about your child’s health that would impact his/her role as a student?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If your child has a history of allergies, takes medication, wears eyeglasses/contacts or has any health related concerns, it is important to provide this information to the school nurse. The Family Education Rights and Privacy Act (FERPA) has issued regulations which require public schools to obtain written consent to disclose medical information. All information will be held in confidence by the school nurses and will be shared only with other school professionals as necessary. If you have any concerns or questions, please do not hesitate to contact the school health office.

I give my permission for release of information on this form for confidential use in meeting my child’s health and educational needs in school.

________________________________________  __________________________
Signature of Parent/Guardian                  Date
Mantoux Tuberculin Testing Notification Form
(Form to be completed by parent/guardian.)

Student’s Name: ________________________________

In accordance with the rules of the State Department of Education, New Jersey Department of Health and Senior Services’ most recent mandate of November 2016, as well as procedures followed by the Livingston School District:

"All students entering New Jersey schools require tuberculin skin testing when entering the school system for the first time, if BORN in, or TRANSFERRING from, a high TB incidence country NOT listed below."

A further exemption exists "if the student has a documented Mantoux Tuberculin skin test result within the previous six (6) months of school entry."

As mandated by state law, the method of screening to be used is the Mantoux Intradermal Skin Test. Within 48 - 72 hours, the site of the test must be checked and the results documented. The Mantoux test may be done by the school nurse or a local private physician if you prefer.

Students will not be allowed to attend school until this testing has been completed.

New entry or transfer students from the following countries are exempt from Mantoux Tuberculin skin testing:

America Samoa  Andorra  Antigua and Barbuda  Australia
Austria  Barbados  Belgium  Bermuda
Canada  Cayman Islands  Cuba  Cyprus
Czech Republic  Denmark  Dominica  Finland
France  Germany  Greece  Greenland
Grenada  Iceland  Ireland  Israel
Italy  Jamaica  Jordan  Lebanon
Luxembourg  Malta  Monaco  Montserrat
Netherlands  Netherlands Antilles  New Zealand  Norway
Oman  Puerto Rico  Saint Kitts and Nevis  Saint Lucia
Saint Maarten (Dutch)  San Marino  Slovakia  Slovenia
Spain  Sweden  Switzerland  Trinidad and Tobago

United Kingdom of Great Britain and Northern Ireland  USA  USA Virgin Islands

Thank you for your cooperation in this matter.

______________________________________________  ________________________
Signature of Parent Acknowledging Receipt of the Mantoux Information  Date
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:

<table>
<thead>
<tr>
<th></th>
<th>Year</th>
<th></th>
<th>Year</th>
<th></th>
<th>Year</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
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<td>Asthma</td>
<td></td>
<td>Otitis Media</td>
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<td>Operations/Injuries</td>
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<tr>
<td>Drug Sensitivities</td>
<td></td>
<td>Chicken Pox</td>
<td></td>
<td>Rheumatic Fever</td>
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<td></td>
</tr>
<tr>
<td>Lyme Disease</td>
<td></td>
<td>Seizure Disorder</td>
<td></td>
<td>Strep Infections</td>
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<td>Hospitalizations</td>
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<tr>
<td>Hepatitis</td>
<td></td>
<td>Diabetes</td>
<td></td>
<td>Mononucleosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neuromuscular Disease</td>
<td></td>
<td>Heart Disease</td>
<td></td>
<td>Other</td>
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<td>Congenital Defects</td>
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</table>

(Please use page 2 for immunization history.)
## Immunization History

<table>
<thead>
<tr>
<th>Vaccination Type</th>
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<th>Booster Date</th>
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<tr>
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<td>mm/dd/yy 5.</td>
</tr>
<tr>
<td></td>
<td>mm/dd/yy 2.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>mm/dd/yy 3.</td>
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<tr>
<td></td>
<td>mm/dd/yy 4.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>mm/dd/yy 5.</td>
<td></td>
</tr>
<tr>
<td><strong>Tdap</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(for students born after January 1997 and students entering Grade 6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IPV</strong></td>
<td>mm/dd/yy 1.</td>
<td>mm/dd/yy 5.</td>
</tr>
<tr>
<td></td>
<td>mm/dd/yy 2.</td>
<td>mm/dd/yy 4.</td>
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<tr>
<td></td>
<td>mm/dd/yy 3.</td>
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</tr>
<tr>
<td><strong>OPV</strong></td>
<td>mm/dd/yy 1.</td>
<td>mm/dd/yy 5.</td>
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<td></td>
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<tr>
<td></td>
<td>mm/dd/yy 3.</td>
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<tr>
<td></td>
<td>mm/dd/yy 4.</td>
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<tr>
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<tr>
<td></td>
<td>mm/dd/yy 2.</td>
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<tr>
<td></td>
<td>mm/dd/yy 3.</td>
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<td><strong>Measles</strong></td>
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<td>mm/dd/yy 2.</td>
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<tr>
<td><strong>Mumps</strong></td>
<td>mm/dd/yy 1.</td>
<td>mm/dd/yy 2.</td>
</tr>
<tr>
<td><strong>Rubella</strong></td>
<td>mm/dd/yy 1.</td>
<td>mm/dd/yy 2.</td>
</tr>
<tr>
<td><strong>Varicella Zoster</strong></td>
<td>mm/dd/yy 1.</td>
<td>mm/dd/yy 2.</td>
</tr>
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<td><strong>HIB Vaccine</strong></td>
<td>mm/dd/yy 1.</td>
<td>mm/dd/yy 5.</td>
</tr>
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<td>mm/dd/yy 2.</td>
<td>mm/dd/yy 4.</td>
</tr>
<tr>
<td></td>
<td>mm/dd/yy 3.</td>
<td>mm/dd/yy 3.</td>
</tr>
<tr>
<td><strong>Hepatitis A Vaccine</strong></td>
<td>mm/dd/yy 1.</td>
<td>mm/dd/yy 2.</td>
</tr>
<tr>
<td><strong>Hepatitis B Vaccine</strong></td>
<td>mm/dd/yy 1.</td>
<td>mm/dd/yy 3.</td>
</tr>
<tr>
<td><strong>PPD Mantoux</strong></td>
<td>Date:</td>
<td>Read:</td>
</tr>
<tr>
<td><strong>Influenza Vaccine</strong></td>
<td>mm/dd/yy 1.</td>
<td>mm/dd/yy 4.</td>
</tr>
<tr>
<td>(mandatory for pre-school students)</td>
<td>mm/dd/yy 2.</td>
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</tr>
<tr>
<td><strong>Pneumococcal Vaccine</strong></td>
<td>mm/dd/yy 1.</td>
<td></td>
</tr>
<tr>
<td>(mandatory for pre-school students)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Meningococcal Vaccine</strong></td>
<td>mm/dd/yy 1.</td>
<td></td>
</tr>
<tr>
<td>(mandatory for incoming Grade 6 students)</td>
<td>mm/dd/yy 2.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>mm/dd/yy 3.</td>
<td></td>
</tr>
</tbody>
</table>

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**Date of Examination:** __________________________  **Physician’s Signature:** __________________________
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: ______________
# Confidential Medical Information Form

*Form to be completed by parent/guardian.*

**2016/2017 School Year**

<table>
<thead>
<tr>
<th>Student’s Name:</th>
<th>Grade:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Name:</td>
<td>Office Phone Number:</td>
</tr>
</tbody>
</table>

**Does your child take any medication regularly? If yes, Please List in the space provided below.**

The school nurse has my permission to administer the following over-the-counter medications to my child during the school day (parents will be notified prior to the delivery of all medication):

- [ ] Tylenol/Acetaminophen
- [ ] Advil/Motrin/Ibuprofen
- [ ] Tums
- [ ] Cough Drops

**Does/Did your child have any of the following? If YES, please give details below.**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies (seasonal, food, bee stings, medicine): List allergens and types of reactions below. <em>(If an EpiPen is required, a “Physician’s Orders for Allergy Treatment” form must be printed from the school web page, filled out by the physician and submitted each school year.)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma (allergic, exercise induced): Describe symptoms and treatment below. <em>(If an inhaler is necessary, an “Asthma Treatment plan” form must be printed from the school web page, filled out by the physician and submitted each school year.)</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Diabetes:

Seizure Disorder:

Hearing Difficulties:

Eyeglasses/Contact Lenses: *(If yes, when should they be worn?)*

Fainting with Exercise?

Any previous joint disease, injuries, fractures?

Loss of consciousness after injury?

Heart problems, chest pain, palpitations, murmur?
<table>
<thead>
<tr>
<th>Has your child ever been hospitalized? If YES, please list dates and detailed reasons below.</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery? If YES, please list dates and detailed reasons below.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you have any concerns about your child’s health that would impact his/her role as a student?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If your child has a history of allergies, takes medication, wears eyeglasses/contacts or has any health related concerns, it is important to provide this information to the school nurse. The Family Education Rights and Privacy Act (FERPA) has issued regulations which require public schools to obtain written consent to disclose medical information. All information will be held in confidence by the school nurses and will be shared only with other school professionals as necessary. If you have any concerns or questions, please do not hesitate to contact the school health office.

I give my permission for release of information on this form for confidential use in meeting my child’s health and educational needs in school.

---

**Signature of Parent/Guardian** ___________________________  **Date** ___________________________
Mantoux Tuberculin Testing Notification Form
(Form to be completed by parent/guardian.)

Student’s Name: ________________________________

In accordance with the rules of the State Department of Education, New Jersey Department of Health and Senior Services' most recent mandate of July 2005, as well as procedures followed by the Livingston School District:

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A further exemption exists "if the student has a documented Mantoux Tuberculin skin test result within the previous six (6) months of school entry."

As mandated by state law, the method of screening to be used is the Mantoux Intradermal Skin Test. Within 48 - 72 hours, the site of the test must be checked and the results documented. The Mantoux test may be done by the school nurse or a local private physician if you prefer.

Students will not be allowed to attend school until this testing has been completed.

New entry or transfer students from the following countries are exempt from Mantoux Tuberculin skin testing:

- Antigua and Barbuda
- Australia
- Austria
- Barbados
- Belgium
- Bermuda
- Canada
- Cayman Islands
- Cuba
- Cyprus
- Czech Republic
- Denmark
- Finland
- France
- Germany
- Greenland
- Grenada
- Iceland
- Ireland
- Israel
- Italy
- Jamaica
- Jordan
- Lebanon
- Luxembourg
- Malta
- Monaco
- Montserrat
- Netherlands
- Netherlands Antilles
- New Zealand
- Norway
- Oman
- Puerto Rico
- Saint Kitts and Nevis
- San Marino
- Sweden
- Switzerland
- Trinidad and Tobago
- United Kingdom of Great Britain and Northern Ireland
- USA
- USA Virgin Islands
- United Kingdom of Great Britain and Northern Ireland
- US Virgin Islands
- United Kingdom of Great Britain and Northern Ireland

Thank you for your cooperation in this matter.

Signature of Parent Acknowledging Receipt of the Mantoux Information

Date: