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)

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

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*

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

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*

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

Confidential Medical Information Form
(Form to be completed by parent/guardian.)

_____ School Year

Student's Name:	Grade:		
Physician's Name:	Office Phone Number:		
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.		Yes	No
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?			

	Yes	No
Has your child ever been hospitalized? If YES, please list dates and detailed reasons below.		
Surgery? If YES, please list dates and detailed reasons below.		
Do you have any concerns about your child's health that would impact his/her role as a student?		

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***

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

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*

Livingston Public Schools

11 Foxcroft Drive - Livingston, New Jersey 07039

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*

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

Confidential Medical Information Form
(Form to be completed by parent/guardian.)
2016/2017 School Year

Student's Name:	Grade:		
Physician's Name:	Office Phone Number:		
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.		Yes	No
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?			

	Yes	No
Has your child ever been hospitalized? If YES, please list dates and detailed reasons below.		
Surgery? If YES, please list dates and detailed reasons below.		
Do you have any concerns about your child's health that would impact his/her role as a student?		

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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***

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Student's Name: _____

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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		

Thank you for your cooperation in this matter.

_____ _____

Signature of Parent Acknowledging Receipt of the Mantoux Information *Date:*