

Name _____ Sex _____ Date of Birth _____
Address _____ Tel. # _____ Emerg. # _____
Dr.'s Name _____ Dr.'s Address _____
Dr.'s Telephone # _____ Student is entering grade _____

IMMUNIZATION RECORD – DOCTOR CERTIFICATE AND DATES REQUIRED

PLEASE NOTE: All immunizations are required by the New Jersey Board of Health and must be administered
(Attach Copy) before a child may be admitted to Kindergarten.

Does your child have any medical history of the following:

	Yes	No		Yes	No
Allergies to Food or Bites	_____	_____	Frequent headaches	_____	_____
Appendectomy	_____	_____	Frequent sore throats	_____	_____
Asthma	_____	_____	Frequent urinary infections	_____	_____
Broken bones	_____	_____	Gluten Allergy	_____	_____
Chicken Pox	_____	_____	Heart Disorder	_____	_____
Cuts needing a doctor	_____	_____	Hepatitis	_____	_____
Diabetes	_____	_____	Hernia Repair	_____	_____
Drug Sensitivity	_____	_____	Kidney Disorder	_____	_____
Elevated blood pressure	_____	_____	Other	_____	_____
Elevated cholesterol	_____	_____	Persistent mouth breathing	_____	_____
Fainting	_____	_____	Poisoning	_____	_____
Frequent colds	_____	_____	Seasonal Allergies	_____	_____
Frequent digestive disturbance	_____	_____	Seizure Disorder	_____	_____
Frequent pain: Joints	_____	_____	Strep Throat	_____	_____
Muscular	_____	_____	Tonsillectomy/Adenoidectomy	_____	_____
Other	_____	_____			

If yes to any of the above, please give details: _____

Has the child ever had vision examined professionally? Yes _____ No _____
Did the child ever have an eye injury? Yes _____ No _____
Has the child ever had vision questioned in preschool screening? Yes _____ No _____
Has the child ever had hearing examined professionally? Yes _____ No _____
Did the child have frequent ear infections during first five years? Yes _____ No _____
 If so, how was it treated? Tubes in ears _____ Medication _____ Both _____
Is your child presently taking medication? If so specify reason and kind.

Is your child under medical treatment at present? If so specify.

Please indicate any physical condition you feel the school should be aware of.

Parent Signature: _____ Date: _____