# Rosebud Academy

102 W Gloucester Pike Barrington NJ, 08007
preschool@strosenj.com
StRoseNJ.com

**Checklist for Pre-School Parents from the Nurses' Office**

**Per NJ State Law, all students must have the following by the first day of school:**

1. A complete medical packet which can be downloaded from our website. This must be completed in its entirety by **BOTH a physician and a parent. This includes a physical form which must be dated within 365 days of the first day of school, a student health inventory, and a complete immunization form (the requirements for this are in our medical packet).** Please note a child can be **excluded from school** if this is not up to date per NJ State law.
2. NJ State law **requires** that all preschool children (up to 59 months old) must receive a **Flu vaccine** between August 1st and December 31st **of each school year.**

Thank you for your cooperation in these matters. Your child's well-being is a priority to us.

The School Nurses

# Student Health Inventory

Teacher____________________ Grade__________ School____________________

*Your child's learning depends upon good health. To assist in providing health services at school, please complete the following and return this to the School Nurse.*

Name______________________________ Birthdate____________ Boy ☐ Girl ☐
Last First Middle

Parent/Guardian______________________________ Phone #________________

Parent's employment ____________________ ____________________
Father Phone Mother Phone

Emergency Contacts ____________________ ____________________
*(Other than parent)* Name Phone Name Phone

Last School attended________________________________________
Name City State

Doctor's name______________________________ Date of last physical ____________

Dentist's name______________________________ Date of last exam____________

Is student under an orthodontist's care? Yes ☐ No ☐ Doctor's name____________________

Does student have:

Allergies? Yes ☐ No ☐ To drugs, food, insects, pollen? Please list________________
Has the allergy required emergency action in the past? Yes ☐ No ☐
Comments______________________________

Bee sting allergy? Yes ☐ No ☐ Describe reaction ______________________________
Difficult breathing? Yes ☐ No ☐ Need emergency medication? Yes ☐ No ☐

Asthma? Yes ☐ No ☐ Triggered by________________ Treatment________________
Diagnosed by doctor ________________ Date__________

Diabetes? Yes ☐ No ☐ Takes insulin? Yes ☐ No ☐ Date Diagnosed____________

Epilepsy/Seizures Yes ☐ No ☐ Describe seizure ______________________________
Date of last seizure ____________ Medication____________
Is student currently under a doctor's care for seizures? Yes ☐ No ☐

Heart condition? Yes ☐ No ☐ Describe ______________________________
Any physical restrictions? ____________Medication? Yes ☐ No ☐

Bone or joint problems? Yes ☐ No ☐ Describe ______________________________
Any physical restrictions? ____________________

Check off the following regarding health concerns that pertain to student:

**Eyes**: Glasses ☐ Reading ☐ Distance ☐ Contacts ☐ Crossed ☐ Difficulty seeing ☐ Lazy Eye

**Ears**: ☐ Frequent Infections ☐ Tubes ☐ Hearing difficulty, explain

Hearing Aid ☐ Right ☐ Left ☐ Wear at School ☐ Other

**Other**: ☐ nosebleeds ☐ lungs ☐ eating ☐ neurologic ☐ sleeping ☐ headaches ☐ bladder ☐ bowel ☐ skin ☐ dental ☐ phobias ☐ ADD/ADHD ☐ bedwetting

Daily medication at home? Yes ☐ No ☐ At school? Yes ☐ No ☐ Emergency only? Yes ☐ No ☐
Name of medication and reason for taking______________________________
List serious illness or injuries______________________________
Surgeries (*operations*)____________________ Condition that prevents PE participation____________
Other health information or concerns______________________________

*If student requires medication at school, or a change in PE participation, please obtain the appropriate form in the school office.*

The Camden County School Nurse program for non-public schools is administered by the Southern NJ Perinatal Cooperative.

# PRE-SCHOOL PHYSICAL EXAMINATION AND IMMUNIZATION RECORD

Name ______________________________ Date of Birth ______________

**Physical examination record**

Height ______________ Weight ________

Blood pressure __________ Pulse ________

Vision (r) ________ (l) ______ Hearing (r) ______ (l) ______

Eyes ______________ Lungs ____________

Ears, Nose, Throat __________ Abdomen __________

Mouth and teeth __________ Skin ______________

Neck ______________ Genitals/Hernia ______

Heart ______________ Extremities __________

Allergies ______________ Restrictions from activities ________

Recommendations: ____________________________________________

______________________________________________________________

**Pre-school immunizations** * *Required*

# 8 is *recommended* for pre-school entrance (will be required for **kindergarten**).

| Type of Vaccine | Dose 1 | Dose 2 | Dose 3 | Boosters |
|---|---|---|---|---|
| 1 DPT/DTaP | * | * | * | * |
| 2 POLIO | * | * | * | |
| 3 MMR | * | | | |
| 4 VARICELLA (chicken pox) | * one dose *or* disease | | | |
| 5 HIB | * | | | |
| 6 INFLUENZA (before Dec. 31st) | * | | | |
| 7 PNEUMOCOCCAL<br>8 # Hepatitis B | * | | | |

*Doctor's Name (PRINT)* ______________________________________

*Doctor's Address* ____________________________ *Telephone* ____________

*Doctor's Signature* ____________________________ *Date of Exam* ________

Dear Parent/Guardian:

This is a reminder regarding the required influenza immunization for children enrolled in a preschool or child care program. The Influenza Vaccine is required for children ages 6 to 59 months, and must be received annually between September 1 and December 31 of each calendar year.

Please complete and return this form to the school once you have made an appointment for your child. This will help us maintain a tracking system as to when we will receive the appropriate documentation.

If you have any questions, please call me. Thank you for your cooperation.

School Nurse

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Child's Name ________________________________________

School ____________________________

_________ My child has already received the influenza vaccine since September 1st
**Attached is an updated immunization record.**

_________ My child is scheduled to receive the influenza vaccine on ____________________.
**I will send in an updated immunization record after the vaccine is given.**