BLAIRSTOWN TOWNSHIP SCHOOL DISTRICT
1 Sunset Hill Road Post Office Box E
Blairstown, New Jersey 07825
908-362-6111 - Fax:908-362-5989
www.blairstownelem.net

Dr. Patrick Ketch, *Superintendent* Colleen Silvestri, *Principal*
Matthew Herzer, *Business Administrator* Dr. Alyssa Emili, *Supervisor of Special Services*

Immunization Form

Please have your child's doctor fill in the form below or attach a copy of your child's immunization record. Your child's doctor must also complete the Universal Child Health.

Student's Name_____ Date of Birth:_____

Please enter complete dates for each dose (month/date/year).

Vaccine Type:	**Dose #1**	**Dose #2**	**Dose #3**	**Dose #4**	**Dose #5**
DTP/DTAP					
IPV					
MMR					
HIB					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL					
INFLUENZA					
OTHER					

Doctor's Name:_____ Doctor's Phone Number:_____

Doctor's Address:_____

Doctor's Signature:_____ Official Office Stamp:

For Kindergarten Registration: Immunization Form Must Be Returned By August 31.
For all other Registrations: Immunization Form Must Be Returned with registration paperwork

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Developmental History

Name:_____
Last Name First Name Middle Initial/Name

Address:_____
Street City State Zip

Father's Name:_____ Mother's Name:_____

Date of Birth:_____

Birth History
Length of Pregnancy:_____

Did you have any complications during the pregnancy? _____ Yes _____ No

If yes, please describe:_____

Child's birth weight:_____ length:_____

List any complications immediately after birth:_____

At what age did your child: sit alone_____ walk alone_____ first word_____
Toilet trained: bowel_____ bladder_____

List all daily medications and reason for taking:_____

List all allergies:_____

_____ My child is currently being desensitized

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Date of complete eye examination:_____

Glasses/Contacts:_____ Please check Reading_____Distance_____ Both_____

Date of complete hearing evaluation:_____

Please check all that pertain to your child and indicate age or date:

Check box:	**Name:**	**Date or Age:**	**Check box:**	**Name:**	**Date or Age:**
	Convulsive disorder			Eczema	
	Pneumonia			Bronchitis	
	Wheezing Asthma/RDA			Frequent Sore Throat	
	Tendency to Bleed Easily			Cardiac History	
	Ear Infections			Phys. Ed Exempt	

Please list any operations/hospitalizations/serious injuries:_____

_____

Any Additional Information:_____

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Current Medical History Form

Student's Name:_____ DOB:_____ Grade:_____

Please list any recent physical examinations, updated immunizations, medications or special considerations for your child. If your child needs any medications/inhalers at school, please contact the school nurse to obtain the appropriate paperwork for your child's physician to complete.

_____

_____

Many children are allergic to certain foods, environments, animals, or medications. A physician must document all true allergic reactions. If your child has reacted due to an allergy, please contact the school nurse to obtain the appropriate paperwork for your child's physician to complete.

_____ My child does not have any known allergies

_____ My child has a diagnosed life-threatening allergy to _____

_____ My child has a diagnosed severe local reaction to _____

_____ My child cannot tolerate the foods _____ and is

_____controlled from home (moderate intake)
_____self-limited by the child
_____requires total abstinence from (contact school nurse)
_____requires strict supervision (contact school nurse)
_____there are no known special considerations

Please provide any medical information to staff/faculty as needed. This will assist us in providing a safe, wholesome environment.

Parent Signature:_____ Date:_____