TENAFLY PUBLIC SCHOOLS
Tenafly, New Jersey

IMMUNIZATION REGISTRY NUMBER

Name of Child (Last, First, M.I.)	Date of Birth (Mo/Day/Yr)	Sex ❑ Male ❑ Female

PARENT OR GUARDIAN	NAME	TELEPHONE NO.
	ADDRESS	

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	LEAD SCREENING	
						Test Date	Result
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination *(If Td or Dt, indicate in corner box)							
Tdap							
POLIO - INACTIVATED POLIO VACCINE(IPV) If oral vaccine, indicate (OPV) in corner box							
MEASLES, MUMPS, RUBELLA (MMR)					TB Screening [Mantoux]	Date / Results [MM]	
HAEMOPHILUS B (HIB)**							
HEPATITIS B							
VARICELLA					Chest Xray	Date / Results	
PNEUMOCOCCAL CONJUGATE**							
MENINGOCOCCAL					Therapy	Started / Completed	
HEPATITIS A ***							
HPV (HUMAN PAPILLOMAVIRUS) ***							
OTHER					BCG	Date	

HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR
ALLERGIES		DRUG ALLERGIES		NEUROMUSC. DISODER		AUTISM SPECTRUM DISORDERS	
ASTHMA		HEART DISEASE		Chronic otitis media		HEMATOLOGICAL DISORDERS	
CONGENITAL DISORDER		HEPATITIS		AUTO IMMUNE DISORDERS		OPERATIONS OR INJURIES	
CONVULSIVE DISORDER		LYME DISEASE		STREP INFECTIONS			
DIABETES		MONONUCLEOSIS		JUVENILE RHEUMATOID ARTHRITIS			

Is child receiving medication ❑ No ❑ Yes if yes, explain: ____________

PRIVATE PHYSICIAN'S REPORT

EXAMINATION

Check if normal, otherwise (x) and give details.

General Condition ____________

Height ________ Weight ________

Eyes ________ Vision R 20/ ______ L 20/ ______

Ears ________ Hearing ________

Throat ________ Teeth ________

Heart ________ Blood Pressure ________

Abdomen ________ Hernia ________

Gait ________ Neuro ________

Skin ________

Feet ________ Posture ________ Spine ________

Other ________

Hqb ________ Urine ________

PHYSICIAN'S REMARKS

____________ is in ________ condition and may safely engage in all usual activities, except as noted above.

Date of Examination [Mo/Day/Yr] ____________

____________ M.D.

Physician's stamp required