

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	
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination <i>*(If Td or Dt, indicate in corner box)</i>						Test Date	Result
Tdap							
POLIO - INACTIVATED POLIO VACCINE(IPV) If oral vaccine, indicate (OPV) in corner box							
MEASLES, MUMPS, RUBELLA (MMR)						TB Screening [Mantoux]	Date
HAEMOPHILUS B (HIB)**							Results [MM]
HEPATITIS B						Chest Xray	Date
VARICELLA							Results
PNEUMOCOCCAL CONJUGATE**						Therapy	Started
MENINGOCOCCAL							Completed
HEPATITIS A ***						BCG	Date
HPV (HUMAN PAPILLOMAVIRUS) ***							
OTHER							

HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR
ALLERGIES		DRUG ALLERGIES		NEUROMUSC. DISORDER		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] _____

Physician's stamp required M.D.