PARK RIDGE PUBLIC SCHOOLS
85 Pascack Road
Park Ridge, NJ 07656

Phone: 201-573-6000

New Student Registration
Student Health Information Release Form

Parents/Guardians: If your child has a history of allergies, takes medication, wears eyeglasses/contacts or has any health related concerns, it is important to give that information to the school nurse. The Family Education Rights and Privacy Act (FERPA) has issued regulations which require public schools to obtain written consent to disclose medical information. All information will be held in the confidence by the school nurses and will be shared only with other school professionals as necessary. If you have any concerns or question, please do not hesitate to contact the school health office.

Student Name:______________________________ Date of Birth: ________________

Home Phone: ________________________ Emergency Contact Phone: ______________

School: ______________________ Teacher: ______________ Grade: __________

	Check one *(if yes, please specify)*:		
Allergies	☐Yes	☐No	*(If an EpiPen injection is necessary, a "permission to dispense" form must be submitted every school year.)*
Asthma	☐Yes	☐No	*(If an inhaler is necessary, a "permission to dispense" form must be submitted every school year.)*
Hearing Difficulties	☐Yes	☐No	
Vision Difficulties	☐Yes	☐No	☐ Eyeglasses ☐ Contact Lenses ☐ Other:
Seizure Disorder	☐Yes	☐No	
Orthopedic Difficulties/Walking Aides	☐Yes	☐No	
Medications *(list condition and dosage)*	☐Yes	☐No	

Other pertinent information (including hospitalizations within the last year):

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.

______________________________	______________________________	__________
Parent/Guardian Name (please print)	Parent/Guardian Signature	Date

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New Student Registration
Student Medical Examination
(to be completed by a licensed health provider)

Student Name: ______________________ Date of Birth: __________ ☐ Female ☐ Male

Home Address: ____

School: ______________________ Grade: ______________

Immunization History:

DTaP: 1. ______ mm/dd/yy 2. ______ mm/dd/yy 3. ______ mm/dd/yy 4. ______ mm/dd/yy 5. ______ mm/dd/yy ______ Booster

Tdap:
(for students born after January 1997 and students entering Grade 6) ______ Booster

Polio

IPV: 1. ______ mm/dd/yy 2. ______ mm/dd/yy 3. ______ mm/dd/yy 4. ______ mm/dd/yy 5. ______ mm/dd/yy

OPV: 1. ______ mm/dd/yy 2. ______ mm/dd/yy 3. ______ mm/dd/yy 4. ______ mm/dd/yy 5. ______ mm/dd/yy

MMR: 1. ______ mm/dd/yy 2. ______ mm/dd/yy 3. ______ mm/dd/yy

Measles: 1. ______ mm/dd/yy 2. ______ mm/dd/yy

Mumps: 1. ______ mm/dd/yy 2. ______ mm/dd/yy **Varicella Zoster:** 1. ______ mm/dd/yy 2. ______ mm/dd/yy

Rubella: 1. ______ mm/dd/yy 2. ______ mm/dd/yy

HIB Vaccine: 1. ______ mm/dd/yy 2. ______ mm/dd/yy 3. ______ mm/dd/yy 4. ______ mm/dd/yy 5. ______ mm/dd/yy

Hepatitis A Vaccine: 1. ______ mm/dd/yy 2. ______ mm/dd/yy

Hepatitis B Vaccine: 1. ______ mm/dd/yy 2. ______ mm/dd/yy 3. ______ mm/dd/yy

PPD Mantoux: Date Tested: ______ Date Read: ______ Results: ______

Lead Test: Date Tested: ______ Lead Level: ______

Influenza Vaccine:
(mandatory for pre-school students) 1. ______ mm/dd/yy 2. ______ mm/dd/yy 3. ______ mm/dd/yy 4. ______ mm/dd/yy

Pneumonoccal Vaccine:
(mandatory for pre-school students) 1. ______ mm/dd/yy

Meningococcal Vaccine:
(mandatory for incoming Grade 6 students) 1. ______ mm/dd/yy 2. ______ mm/dd/yy 3. ______ mm/dd/yy

Other (specify): ______________________________

Park Ridge Public Schools

PARK RIDGE PUBLIC SCHOOLS
85 Pascack Road
Park Ridge, NJ 07656
Phone: 201-573-6000

New Student Registration
Student Medical Examination
(to be completed by a licensed health provider)

Student Name: ______________________ Date of Birth: __________ ☐ Female ☐ Male

Home Address: ____

School: ______________________ Grade: ______________

Growth and Development: Normal __________ Premature __________ Term __________

Complications ____

Early illness or injury ____

Systems Review:

Height __________ Weight __________ BMI __________ Blood Pressure __________

Vision: R ______ L ______ B ______ Glasses/Contacts ______________

Audio: R ______ L ______ ENT ______________ Speech ______________

Integument __________ Head & Neck __________ Lymphatic __________

Respiratory __________ Cardiovascular __________ Abdomen __________

Gastrointestinal __________ Genitourinary __________ Urinalysis __________

Musculoskeletal __________ Hernia __________ Scoliosis __________

Nervous __________ Emotional Symptoms __________ Nutrition __________

Neurological/Psychological: ____

General Assessment: ____

Remarks (Please list any special needs and/or medication required.): ______________

____

____

Medical History:

	Year		Year		Year		Year
Allergies		Asthma		Ottis Media		Operations/Injuries	
Drug Sensitivities		Chicken Pox		Rheumatic Fever			
Lyme Disease		Seizure Disorder		Strep Infections		Hospitalizations	
Hepatitis		Diabetes		Mononucleosis			
Neuromuscular Disease		Heart Disease		Other		Congenital Defects	

Date of Examination: ______________ Physician's Signature: ______________________

______________________ ______________________ ______________

Physician's Name *(please print)* Office Address Office Phone