



Health Services Information

All new students entering the Hanover Township Public Schools must have the following health-related documentation on record **prior to his/her first day of school**. If registering for the next school year, please provide the completed Health Services Information packet at the time of your registration appointment.

Pursuant to Title 8-Chapter 57, New Jersey Department of Health and Regulations require that all New Jersey pupils be immunized with the following vaccines. **No pupil will be admitted to any school in our district without evidence of having been immunized** by providing a complete immunization record compliant with NJDOH mandates.

Preschool Entrance Requirements at Bee Meadow School:

- DTaP (Diphtheria, Tetanus, acellular pertussis) – 4 doses with one of these doses given on or after the 4th birthday OR any 5 doses
- Polio, Inactivated Polio Vaccine (IPV) – 3 doses with one of these doses given on or after the 4th birthday OR any 4 doses
- MMR (Measles, Mumps, Rubella) – 1 dose
- Varicella – 1 dose
- Hib (*Haemophilus influenzae type b*) – at least 1 dose given on or after the first birthday
- Pneumococcal conjugate (PCV 13) – at least 1 dose given on or after the first birthday
- Influenza – 1 dose due each year by December 31 for students through 59 months of age

Elementary School Requirements:

- DTaP (Diphtheria, Tetanus, acellular pertussis) – 4 doses with one of these doses given on or after the 4th birthday OR any 5 doses
- Polio, Inactivated Polio Vaccine (IPV) – 3 doses with one of these doses given on or after the 4th birthday OR any 4 doses
- MMR (Measles, Mumps, Rubella) – 1 dose
- Varicella – 1 dose
- Hepatitis B – 3 doses

Mandatory for Entrance into Memorial Junior School (Grade 6):

- Tdap booster vaccine
- Meningococcal vaccine

Pursuant to N.J.A.C. 6A:16-2.2, upon entering the school district, each child must have an up-to-date physical examination. This examination must have been completed by a licensed healthcare provider no more than 365 days prior to entering school. Failure to submit a Student Medical Examination/Immunization Record could result in your child's exclusion from school.

- Student Medical Examination
- Immunization Record
- Dental Form
- Tuberculosis Screening Test Result (if applicable)
 - Only required for new students entering school for the first time from high-risk countries
 - If you are uncertain whether or not this pertains to you, please contact your school nurse



Student Medical Examination

(Pages 1 & 2 to be completed by a licensed healthcare provider)

Student Name _____ D.O.B. _____ Female Male
 Address _____ City _____ Zip Code _____

Early Growth and Development

Birth: Premature <input type="checkbox"/> Term <input type="checkbox"/>
Pregnancy/Birth Complications:
Early Illness or Injury:

Systems Review

Height		Weight		BMI		BP/HR	
Vision R		Vision L		Vision Both		Glasses/ Contacts	
Audio R		Audio L		EENT		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):



Student Medical Examination (Page 2)

(Pages 1 & 2 to be completed by a licensed healthcare provider)

Medical History

	Y/N		Y/N		Y/N
Food Allergies		Convulsive Disorder		Cardiac Disorder	
Drug Allergies		Neuromuscular Disorder		Diabetes	
Non-Food/Non-Drug Allergies		Neurological Disorder		Asthma	
Behavioral Disorder		Hematological Disorder		Hepatitis	
Emotional Disorder		Autoimmune Disorder		Lyme Disease	
ADD/ADHD		ENT Disorder		Hospitalizations	
Autism Spectrum Disorder		Renal Disorder		Surgeries/Injuries	
Congenital Disorder		Gastrointestinal Disorder		Other	

If yes to any of the above, provide diagnosis, treatment plan, and any related restrictions:

Date of Exam: _____

Name of Licensed Healthcare Provider (print): _____

Signature of Licensed Healthcare Provider: _____

Phone Number: _____



Hanover Township PUBLIC SCHOOLS

Immunization Record

(May use copy of electronic health record in place of this form)

Vaccine Type	1st Dose mm/dd/yr	2nd Dose mm/dd/yr	3rd Dose mm/dd/yr	4th Dose mm/dd/yr	5th Dose mm/dd/yr
DTaP (Diphtheria, Tetanus, acellular pertussis)					
Polio, Inactivated Polio Vaccine (IPV)					
MMR (Measles, Mumps, Rubella)					
Varicella					
Hepatitis B					
Tdap					
Meningococcal					
Hib (<i>Haemophilus influenzae</i> type b)					
Pneumococcal conjugate (PCV 13)					
Influenza					
Other:					
Other:					
PPD Mantoux Date Tested:		Date Read:		Result:	
IGRA/QuantIFERON-TB Gold Date Tested:		Result:			



Hanover Township PUBLIC SCHOOLS

Dental Form (To be completed by Dentist)

Student Information

Name _____ D.O.B. _____

Dentist Information

Name _____

Address _____ City _____ Zip Code _____

Phone _____ Fax _____

Date of Last Dental Exam _____

Describe dental care student requires:

Signature of Dentist

Date