

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

PHYSICIAN'S REMARKS

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 _____

_____ 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.