Scotch Plains-Fanwood Public Schools
512 Cedar Street
Scotch Plains, NJ 07076

Dear Parents/Guardians,

Welcome to the Scotch Plains–Fanwood Public Schools!

We look forward to working with you and your child in the coming year. In order to ensure the safety of all our students, your collaboration is very important. Please refer to the following guidelines regarding the information that you must submit prior to your child starting school.

Medical Requirements

- The Scotch Plains–Fanwood Board of Education requires each new student, entering the district, to submit proof of a physical examination in accordance with NJ State Administrative Code 6A:16.2.
- Each new student must also have proof of the immunizations required, in accordance with NJ State Administrative Code 8:57-4, unless there are special circumstances. If your child has not received their immunizations due to medical or religious reasons, or you have recently moved into the state/country please contact us for the necessary paperwork.
- If your child is transferring from another country, or was born outside of the United States, please contact us about the possible need for a Tuberculin test.
- In the event your child has a food allergy or medical concern that would require medication to be administered at school, please contact your school nurse for the necessary paperwork to maintain your child's health during the school year.

All students entering the Scotch Plains–Fanwood Public Schools for the first time should have the following forms completed ***prior*** to the first day of school:

1) The **Universal Child Health Record** regarding physical examination, immunizations, medical conditions and preventive health screenings completed by your **child's physician.**

   * Please note that immunization records **must** be on file in the Health Office before your child can begin school, unless there are special circumstances that have already been cleared by the building nurse.

2) The district **Student & Family Health Questionnaire** form completed by the **parent/guardian**.

Please call us with any questions or concerns.

Sincerely,

The SPF School Nurses

Ms. Paine Brunner (908) 889-2148	Mrs. Cappadoccia Coles (908) 757-7555	Mrs. Tomasulo Evergreen (908) 889-5331	Mrs. Hottenstein McGinn (908) 233-7950	Ms. Cristaldi School One (908) 322-7731
	Ms. Lambo Ms. Pope Terrill (908) 322-5215	Mrs. Feeley Mrs. Shaughnessy Park (908) 322-4445	Mrs. McNally Mrs. McCarthy SPFHS (908) 889-8600	

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APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

SCOTCH PLAINS-FANWOOD PUBLIC SCHOOLS
STUDENT & FAMILY HEALTH QUESTIONNAIRE

This record is to be filled in by the parent or guardian and provided to the school nurse.

LAST NAME _____ FIRST NAME _____ INITIAL _____ BIRTHDATE _____ GENDER _____

ADDRESS _____ PHONE _____

PARENT 1 _____ PARENT 2 _____

PERSONAL HEALTH HISTORY

Birth weight _____lbs. _____oz.

	YES	NO
Illness of mother during pregnancy	❒	❒
Born prematurely	❒	❒
Complications of delivery	❒	❒
Difficulty soon after delivery	❒	❒

Specify: _____

Walked alone when _____ months old

Said a few words when _____ months old

Has child had/has:	YES	NO	DATE
Serious bee sting allergy	❒	❒	_____
Hernia	❒	❒	_____
Chickenpox	❒	❒	_____
Rheumatic Fever	❒	❒	_____
Asthma or wheezing	❒	❒	_____
Pneumonia or bronchitis	❒	❒	_____
Frequent sore throats	❒	❒	_____
Frequent ear infections	❒	❒	_____
Trouble with hearing	❒	❒	_____
Trouble with speech	❒	❒	_____
Celiac Disease	❒	❒	_____
Diabetes	❒	❒	_____

Has child had:	YES	NO	DATE
Trouble with vision	❒	❒	_____
Frequent vomiting or diarrhea	❒	❒	_____
Tendency to bleed easily	❒	❒	_____
Allergies	❒	❒	_____
Convulsions or other seizures	❒	❒	_____
Unusual nervousness, nail biting, or thumb sucking	❒	❒	_____
Nightmares or trouble sleeping	❒	❒	_____
Breath-holding or temper tantrums	❒	❒	_____
Difficulty with toilet training or bedwetting	❒	❒	_____
Any severe injury or impairments	❒	❒	_____

Specify: _____

Any operations: ❒ ❒ _____

Specify: _____

Any medication: ❒ ❒ _____

Specify: _____

FAMILY HEALTH HISTORY

Has parent or sibling had:	YES	NO	Relationship
Significant Allergy	❒	❒	_____
Rheumatic Fever	❒	❒	_____
Heart Disease	❒	❒	_____
Diabetes	❒	❒	_____
Tuberculosis	❒	❒	_____
Convulsive Disorder	❒	❒	_____
Mental Illness	❒	❒	_____
Cancer	❒	❒	_____
Other	❒	❒	_____

ADDITIONAL INFORMATION

	YES	NO	
Previous Schooling:	❒	❒	Where? _____
Another Language Spoken at Home:	❒	❒	What? _____
Child born in the United States:	❒	❒	If no, years in United States? _____

Other significant health issues/learning problems: _____

Parent/Guardian Signature _____ Date _____

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FOR CHILD CARE/PRESCHOOL DIRECTORS AND PARENTS: CHILD CARE/PRESCHOOL IMMUNIZATION REQUIREMENTS

NJ Department of Health
Vaccine Preventable Disease Program

New Jersey Minimum Immunization Requirements for Child Care/Preschool Attendance
N.J.A.C. 8:57-4 Immunization of Pupils in School

Listed in the chart below are the minimum required number of doses your child must have in order to enroll/attend a child care/preschool facility in NJ. Additional vaccines are recommended by the Advisory Committee on Immunization Practices (ACIP), but only the following are required for child care/preschool attendance in NJ. For the complete ACIP Recommended Immunization Schedule, please visit http://www.cdc.gov/vaccines/schedules/index.html.

At this age the child should have received the following vaccines:	**2 months**	**4 months**	**6 months**	**12 months**	**15 months**	**18 months**	**19 months**	**20-59 months**
Diphtheria, tetanus & acellular pertussis (DTaP)	Dose #1	Dose #2	Dose #3			Dose #4		
Inactivated Poliovirus (Polio)	Dose #1	Dose #2				Dose#3		
Haemophilus influenzae type b (Hib)	Dose #1	Dose #2		1-4 doses* (see footnote)		At least 1 dose given on or after the first birthday		
Pneumococcal conjugate (PCV 13)	Dose #1	Dose #2		1-4 doses* (see footnote)	At least 1 dose given on or after the first birthday			
Measles, mumps, rubella (MMR)					Dose #1†			
Varicella (VAR)							Dose #1 §	
Influenza (IIV; LAIV)			One dose due each year ¶					

Interpretation: Children need to receive the minimum number of age-appropriate vaccines prior to entering child care/preschool. For example, a child 2 months of age, must have 1 dose each of DTaP, Polio, Hib, and PCV before being permitted to enter child care/preschool. A child entering at a younger age range than listed above must have proof of receiving vaccines in the previous age bracket. Example: A child entering child care/preschool at 11 months of age, would need at least the following: 3 DTaP, 2 Polio, 2 Hib, and 2 PCV. The current seasonal flu vaccine is required every year by December 31 for children 6-59 months of age.

[*] *Haemophilus influenzae* type b (Hib) and pneumococcal (PCV) vaccines are special cases. If a child started late with these vaccines he/she may need fewer doses. One dose of each is required on or after the first birthday in all cases.
Please Note: The use of combination vaccines may allow students to receive the 1st birthday booster dose of Hib between 15-18 months of age.

[†] **MMR vaccine may be given as early as 12 months of age**, but NJ requires children to receive the vaccine by 15 months of age. Prior to age 15 months, a child may enter preschool/child care without a documented dose of MMR.

[§] **Varicella vaccine may be given as early as 12 months of age**, but NJ requires children to receive the vaccine by 19 months of age. Prior to age 19 months, a child may enter preschool/child care without a documented dose of varicella. A child will not have to receive the varicella vaccine if he/she previously had chickenpox as long as the parent can provide the school with one of the following: 1. Documented laboratory evidence showing immunity (protection) from chickenpox, 2. A physician's written statement that the child previously had chickenpox, or 3. A parent's written statement that the child previously had chickenpox.

[¶] The current seasonal influenza vaccine is required every year for those children 6 months through 59 months of age. Students who have not received the flu vaccine by December 31 must be excluded (not allowed to attend child care/preschool) for the duration of influenza season (through March 31), until they receive at least one dose of the influenza vaccine or until they turn 60 months of age. Children enrolling in child care/preschool after December 31, must provide documentation of receiving the current seasonal flu vaccine before being allowed to enter school. Students enrolling in school after March 31 are not required to receive the flu vaccine; however, flu season may extend until May and therefore getting a flu vaccine even late in the season is still protective

NJ accepts valid medical and religious exemptions (reasons for not showing proof of immunizations) as per the NJ Immunization of Pupils in School regulations, N.J.A.C. 8:57-4. Children without proof of immunity as defined by ACIP, including those with medical and religious exemptions, may be excluded from a school, preschool, or child care facility during a vaccine preventable disease outbreak or threatened outbreak as determined by the Commissioner, Department of Health or his or her designee. In addition, anybody having control of a school may, on account of the prevalence of any communicable disease, or to prevent the spread of communicable disease, prohibit the attendance of any teacher or pupil of any school under their control and specify the time during which the teacher or scholar shall remain away from school. The Department of Health shall provide guidance to the school of the appropriateness of any such prohibition.

For more information, please visit "NJ Immunization Requirements Frequently Asked Questions", at the following link:
http://nj.gov/health/cd/imm.shtml .

Interpretation: Children need to receive the minimum number of age-appropriate vaccines prior to entering child care/preschool. For example, a child 2 months of age, must have 1 dose each of DTaP, Polio, Hib, and PCV before being permitted to enter child care/preschool. A child entering at a younger age range than listed above must have proof of receiving vaccines in the previous age bracket. Example: A child entering child care/preschool at 11 months of age, would need at least the following: 3 DTaP, 2 Polio, 2 Hib, and 2 PCV. The current seasonal flu vaccine is required every year by December 31 for children 6-59 months of age.

NJ Department of Health
Vaccine Preventable Disease Program

New Jersey Minimum Immunization Requirements for Kindergarten-Grade 12 Attendance
N.J.A.C. 8:57-4 Immunization of Pupils in School

Guide for checking compliance

Step 1: Each child attending/enrolling must present documentation of immunizations or valid medical or religious exemption to vaccines. In order to allow a child to enter school, he/she must have at least one dose of each age-appropriate required vaccine.

Step 2: Determine child's present grade level.

Step 3: Compare the child's record with the requirements listed on the chart below.

Grade/level child enters school:		**Minimum Number of Doses for Each Vaccine**						
		DTaP Diphtheria, Tetanus, acellular Pertussis	**Polio Inactivated Polio Vaccine (IPV)**	**MMR (Measles, Mumps, Rubella)**	**Varicella (Chickenpox)**	**Hepatitis B**	**Meningococcal**	**Tdap (Tetanus, diphtheria, acellular pertussis)**
Kindergarten – 1st grade		A total of 4 doses with one of these doses on or after the 4th birthday OR any 5 doses*	A total of 3 doses with one of these doses given on or after the 4th birthday OR any 4 doses*	2 doses†	1 dose	3 doses	None	None
2nd – 5th grade		3 doses *NOTE: Children 7 years of age and older, who have not been previously vaccinated with the primary DTaP series, should receive 3 doses of Tetanus, diphtheria (Td)*	3 doses	2 doses	1 dose	3 doses	None	None
6th grade and higher		3 doses	3 doses	2 doses	1 dose required for children born on or after 1/1/98§	3 doses¶	1 dose required for children born on or after 1/1/97 given no earlier than ten years of age**	1 dose required for children born on or after 1/1/97 **

Additional vaccines are recommended by the Centers for Disease Control and Prevention (CDC). The chart above lists only the vaccines that are required for school attendance in NJ. Please note that unvaccinated children, including those with medical and/or religious exemptions, may be excluded from school during a vaccine preventable disease outbreak or threatened outbreak to ensure public health safety.

For the complete CDC Recommended Immunization Schedule, please visit http://www.cdc.gov/vaccines/schedules/index.html.

* **DTaP:** Children who previously attended child care/preschool should have received 4 doses since the requirement to receive the fourth birthday booster dose (5th dose) does not apply until the child attends Kindergarten. However, if one of these 4 doses was given after the 4th birthday, this child will not need an additional dose for Kindergarten. Children will need 5 doses if all doses were administered prior to the 4th birthday in order to enter Kindergarten.

Polio: Children who previously attended child care/preschool should have 3 doses since the requirement to receive the fourth birthday booster dose (4th dose) does not apply until the child attends Kindergarten. However, if one of these 3 doses was given after the 4th birthday, this child will not need an additional dose for Kindergarten.

Children will need 4 doses if all doses were administered prior to the 4th birthday.

† A child is required to receive two doses of measles, one dose of mumps, and one dose of rubella once he/she enters Kindergarten. Since single antigen (separate components of the vaccine) is not readily available, most children will have two MMR vaccines.

The Antibody Titer Law (Holly's Law, NJSA 26:2N-8-11), passed on January 14, 2004, requires the New Jersey Department of Health (NJDOH) to accept serologic evidence of protective immunity to measles, mumps and rubella in lieu of the second ACIP recommended measles, mumps and rubella vaccine. For more information, please visit http://nj.gov/health/cd/documents/antibody_titer_law.pdf.

§ Varicella vaccine is only required for children born on or after January 1, 1998. A child will not have to receive the varicella vaccine if he/she previously had chickenpox as long as a parent can provide the school with one of the following: 1) Documented laboratory evidence showing immunity (protection) from chickenpox, 2) A physician's written statement that the child previously had chickenpox, or 3) A parent's written statement that the child previously had chickenpox.

¶ Two doses of hepatitis B vaccine is acceptable if child received the vaccine between 11 – 15 yrs. of age AND the vaccine is identified as Adolescent Formulation.
Children who present documented laboratory evidence of hepatitis B disease or immunity, constituting a medical exemption, shall not be required to receive hepatitis B vaccine.

** Tdap and Meningococcal vaccines are required for all entering 6th graders who are 11 years of age or older; 6th graders < 11 years must receive Tdap and meningococcal vaccines once age 11 is reached.

For the complete list of "NJ Immunization Requirements Frequently Asked Questions", please visit http://nj.gov/health/cd/imm.shtml.