# ADMISSION MEDICAL FORM

**Dear Doctor,**

**You are examining this child for admission to the Heritage Children's Academy. The child will be in a group with many others of his/her age, and will participate in active play periods throughout the day. We would appreciate your comments on any unusual physical conditions, giving your recommendations where applicable. Please give special attention to the recording of immunizations listed.**

**To be filled out by Parent:**

**Child's Name** _____ **Birth Date** _____ **Dr's Name** _____
**Family History:**
**Communicable Diseases (TB, Other)** _____ **Allergies** _____
**Birth Weight** _____ **Normal Delivery?** _____ **Explain** _____
**Still taking bottle?** _____ **Age Weaned** _____ **First walked** _____ **Talked** _____
**Age toilet trained** _____ **Unusual Conditions** _____

**Has Child Had:**
**Eczema** _____ **Measles** _____ **Pneumonia** _____ **Ch. Pox** _____ **Asthma** _____ **Croup** _____
**Otitis Media** _____ **Scarlet Fever** _____ **Rheu. Fever** _____ **Convulsions** _____
**Injuries/Operations** _____

**To be filled out by Doctor:**

**Medical Exam:**
**Skin** _____ **Scalp** _____ **Fontanels** _____ **Mucous Membranes** _____ **Head** _____ **Eyes** _____
**Ears** _____ **Nose** _____ **Teeth** _____ **Throat** _____ **Lymph Nodes** _____ **Thyroid** _____ **Thorax** _____
**Lungs** _____ **Heart** _____ **Abdomen** _____ **Tonsils** _____ **Genitalia** _____ **Spine** _____
**Extremeties** _____ **Reflex** _____ **Posture** _____ **Nutrition** _____
**Is child on medication for any condition if YES, explain**

**New Jersey Department of Health**
**STANDARD SCHOOL / CHILD CARE CENTER IMMUNIZATION RECORD**

| NAME OF CHILD (Last, First, MI) | | DATE OF BIRTH (Mo/Day/Yr) | SEX ☐M ☐F |
|---|---|---|---|
| NAME OF PARENT/GUARDIAN | | TELEPHONE NUMBER(S) | |
| ADDRESS | | | |
| ADDRESS | | IMMUNIZATION REGISTRY NUMBER | |

| 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 *(Not Required)* TEST DATE | RESULT |
|---|---|---|---|---|---|---|---|
| DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT[1], indicate in corner box) | | | | | | | |
| POLIO-INACTIVATED POLIO VACCINE (IPV) (If oral vaccine, indicate OPV in corner box) | | | | | | | |
| MEASLES, MUMPS, RUBELLA (MMR) | | | | | | | |
| HAEMOPHILUS B (HIB) | | | | | | | |
| HEPATITIS B (HepB) | | | | | | | |
| VARICELLA | | | | | | | |
| PNEUMOCOCCAL CONJUGATE (PCV13) | | | | | | | |
| INFLUENZA | | | | | | | |
| OTHER, SPECIFY: | | | | | | | |
| OTHER, SPECIFY: | | | | | | | |
| OTHER, SPECIFY: | | | | | | | |

[5] Document below single antigen vaccine receipt, serology titers, or varicella disease history

| | | |
|---|---|---|
| Hepatitis B | DATE: | TITER: |
| Varicella | DATE: | TITER: |
| Measles | DATE: | TITER: |
| Mumps | DATE: | TITER: |
| Rubella | DATE: | TITER: |

Exemptions:
☐ Medical Exemption Attached
☐ Religious Exemption Attached

☐ Provisional Admission Date Granted: ____/____/____

[1] REQUIRES MEDICAL EXEMPTION.

**A complete list of New Jersey's immunization requirements is accessible at: http://nj.gov/health/cd/imm_requirements**

IMM-8
OCT 17