

# STATE OF NEW JERSEY HEALTH HISTORY AND APPRAISAL

IMMUNIZATION REGISTRY NUMBER

Name of Child (Last, First, M.I.)		Date of Birth (Mo/Day/Yr)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>PARENT OR GUARDIAN</b>	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)						Document below single antigen vaccine receipt, serology titers, or varicella disease history	
HAEMOPHILUS B (HIB)**							
HEPATITIS B						Hepatitis B	Date: _____ Titer: _____
VARICELLA						Varicella	Date: _____ Titer: _____
PNEUMOCOCCAL CONJUGATE **						Measles	Date: _____ Titer: _____
MENINGOCOCCAL						Mumps	Date: _____ Titer: _____
HEPATITIS A ***						Rubella	Date: _____ Titer: _____
HPV (HUMAN PAPILLOMAVIRUS) ***							
OTHER							

Provisional admission attached–Date Granted: \_\_\_\_\_  Medical exemption attached  Religious exemption attached

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		<b>OPERATIONS OR INJURIES</b>	
CONVULSIVE DISORDER		LYME DISEASE		STREP INFECTIONS			
DIABETES		MONONUCLEOSIS		JUVENILE RHEUMATOID ARTHRITIS			

HEALTH SCREENING CODE: N = Normal; R = Referred; T = Under Treatment; C = See Comments

Grade/Age	/											
Date	/											
Height	/											
Weight	/											
Blood Pressure	/											
V I S I O N	With correction	R	/									
		L	/									
		BOTH	/									
	Without correction	R	/									
		L	/									
		BOTH	/									
	Muscle Balance	/										

Color Perception	Date	Results										
H E A R I N G	Date	/										
	Sweep Check	R	/									
		L	/									

BIENNIAL SCOLIOSIS SCREENING      Date      Date      Date      Date      Date

(Beginning at Age 10)

Referred for abnormal result                             

TB Screening (Mantoux Test)		Chest X-Ray			Medication	
Tested	Date	Date	Date	Date	Normal	Abnormal
Read	_____	_____	_____	_____	_____	_____
Result (MM)	_____	_____	_____	_____	_____	_____
					Reactor No Rx <input type="checkbox"/>	
					Date Started _____	
					Date Completed _____	

