

MONTGOMERY TOWNSHIP SCHOOL  
SKILLMAN, NEW JERSEY

**ORCHARD HILL ELEMENTARY SCHOOL  
VILLAGE ELEMENTARY SCHOOL  
HEALTH SERVICES**  
OHES (609)466-7605, ext. 1600; VES (609)466-7606 ext. 2600

**MEDICAL DOCUMENTATION FOR KINDERGARTEN**

- **REQUIRED: Copy of most updated immunization record – to be provided at time of registration.** Below are the minimum immunization requirements for Kindergarten. The principal shall not knowingly admit or retain any child whose parent or guardian has not submitted acceptable evidence of the child's immunizations, according to the New Jersey Department of Health Minimum Immunization Requirements for School Attendance (N.J.A.C. 8:57 Subchapter 4. Please see School Nurse for exceptions to this requirement. **Not providing the appropriate documentation may detain your child from starting school on the first day in September 2025.** You will be contacted by the certified school nurse at your child's upcoming school if there are any immunizations that are missing.

**DTaP** – 4 doses, with one dose given on or after the 4<sup>th</sup> birthday, OR any 5 doses.

**Polio** – 3 doses, with one dose given on or after the 4<sup>th</sup> birthday, OR any 4 doses.

**Measles**- 2 doses of a live Measles-containing vaccine OR laboratory evidence of immunity.

**Rubella & Mumps**- 1 dose of live Mumps-containing vaccine and 1 dose of live Rubella –containing vaccine.

**Varicella**-1 dose on or after first birthday OR laboratory evidence of immunity, physician's statement or parental statement of previous varicella disease.

**Hepatitis B** - 3 doses OR laboratory evidence of immunity is also acceptable.

*All vaccines must meet the recommended minimum age and dose spacing intervals.*

- **REQUIRED: Physical Exam** – By State Law and the policies of the Montgomery Township Board of Education incoming Kindergarten students are required to have a physical exam. **The physical exam must be performed no earlier than September 1, 2024 and Universal Child Health Form must be provided to the school nurse by September 1, 2025.**
- **Medication** – If your child requires medication (other than an inhaler, nebulizer, or epinephrine pen) to be held in the health office and administered, please contact the school nurse to obtain the necessary paperwork that must be completed by your child's physician and you. Medication forms must be renewed annually. The school nurse will contact you to let you know when to drop off the forms and medication. Please note, medication must be brought in by the parent, students are NOT ALLOWED to transport medications unless they have been approved to self-administer. **If your child has a life-threatening allergy or asthma there are specific Montgomery Township School District forms/plans (attached here) that must be filled out and returned with the prescribed medication.**

# UNIVERSAL CHILD HEALTH RECORD

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

<b>SECTION I - TO BE COMPLETED BY PARENT(S)</b>					
Child's Name (Last) _____ (First) _____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth _____ / _____ / _____	
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____	
<b><i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i></b>					
Signature/Date _____				This form may be released to WIC. Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER</b>					
Date of Physical Examination: _____		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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) _____		
<b>IMMUNIZATIONS</b>		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____			
<b>MEDICAL CONDITIONS</b>					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns: _____		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____		
Medications/Treatments • List medications/treatments: _____		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____		
Limitations to Physical Activity • List limitations/special considerations: _____		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____		
Special Equipment Needs • List items necessary for daily activities _____		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____		
Allergies/Sensitivities • List allergies: _____		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____		
Special Diet/Vitamin & Mineral Supplements • List dietary specifications: _____		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____		
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns: _____		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____		
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for: _____		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments _____		
<b>PREVENTIVE HEALTH SCREENINGS</b>					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> <b><i>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.</i></b>					
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 and Senior Services, Immunization Program at 609-588-7512.

- 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.state.nj.us/health/forms/ch-15.dot](http://www.state.nj.us/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](http://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 health 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.