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
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination *(If Td or Dt, indicate in corner box)*					
Tdap					
POLIO - INACTIVATED POLIO VACCINE(IPV) If oral vaccine, indicate (OPV) in corner box					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB)**					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE**					
MENINGOCOCCAL					
HEPATITIS A ***					
HPV (HUMAN PAPILLOMAVIRUS) ***					
OTHER					

LEAD SCREENING	
Test Date	Result

TB Screening [Mantoux]	Date Results [MM]
Chest Xray	Date Results
Therapy	Started Completed
BCG	Date

HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR
FOOD ALLERGIES		DIABETES		LYME DISEASE		JUVENILE RHEUMATOID ARTHRITIS	
NON-FOOD/NON-DRUG ' ALLERGIES		INFLUENZA (FLU)		MONONUCLEOSIS		AUTISM SPECTRUM DISORDERS	
		OTHER		NEUROMUSC. DISORDER		HEMATOLOGICAL DISORDERS	
ASTHMA		DRUG ALLERGIES		CHRONIC OTITIS MEDIA		ADD/ADHD	
CONGENITAL DISORDER		HEART DISEASE		AUTO IMMUNE DISORDERS		CONCUSSION/TBI	
CONVULSIVE DISORDER		HEPATITIS		STREP INFECTIONS			

Is child receiving medication ❑ No ❑ Yes if yes, explain: _____

PRIVATE PHYSICIAN'S REPORT

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 _____

PHYSICIAN'S REMARKS

_____ is in _____ condition and may safely engage in all usual activities, except as noted above.

Date of Examination [Mo/Day/Yr] _____

_____ M.D.

Physician's stamp required