

# 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 (If Td or DT, indicate in corner box)							
Tdap							
POLIO – INACTIVATED POLIO VACCINE (IPV) <i>If oral vaccine, indicate (OPV) in corner box</i>							
MEASLES, MUMPS, RUBELLA (MMR)						<b>Document below single antigen vaccine receipt, serology titers, or varicella disease history</b>	
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							
OTHER							

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

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			

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

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

Color Perception	Date	Results												
<b>H E A R I N G</b>	Date													
	Pure Tone	R												
		L												

BIENNIAL SCOLIOSIS SCREENING      Date      Date      Date      Date      Date

(Beginning at Age 10)

Referred for abnormal result                             

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

