ROBERT D. REYNOLDS SCHOOL

391 WEST SADDLE RIVER ROAD
UPPER SADDLE RIVER, NEW JERSEY 07458
usrschoolsk8.com

DEVIN A. SEVERS, PRINCIPAL

TELEPHONE 201-961-6300
FAX 201-236-8432

Dear Parents,

Re: Kindergarten Health and Immunization Records

The Sanitary Code of the New Jersey Department of Health and Education requires all children to present documentation of the following *prior* to entering school:

- **2 doses of measles, mumps and rubella with the first dose given on or after the first birthday**
- **4 doses of diphtheria, tetanus and pertussis with 1 given after age 4 (or any combination of 5 doses)**
- **3 doses of polio with 1 given after age 4 (or any combination of 4 doses)**
- **3 doses of hepatitis B**
    - **The minimum interval between the first and second dose:**
        - **Weeks after first dose – 1 month**
    - **There are three minimum intervals that must be met for the third dose:**
        - **Weeks after first dose – 4 months or 16 weeks or 112 days**
        - **Weeks after second dose – 2 months or 8 weeks or 56 days**
        - **Weeks after birth – 6 months or 24 weeks or 168 days**
- **1 dose of varicella vaccine (chicken pox) given on or after the first birthday**

A physical examination report is required for entry into school. The enclosed physical examination form may be completed by your private physician and returned to the Reynolds Health Office, c/o School Nurse, 391 W. Saddle River Road, Upper Saddle River, NJ 07458-1622. Health and immunization records should be provided no later than September first.

Sincerely,

Devin A. Severs

Devin A. Severs,
Principal

1/3/19

REYNOLDS/BOGERT HEALTH OFFICE
UPPER SADDLE RIVER SCHOOL DISTRICT
Physical Examination Report

Name: _____ **Age:** _____ **Date of Birth:** _____

Address: _____ **City/State/Zip:** _____ **Home Phone:** _____

School: _____ **Grade:** _____ **Sex:** _____

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH SIDES

Exam Date: _____

Height: _____ **Weight:** _____ **Blood Pressure:** _____/_____ **Pulse:** _____**bpm.**
Vision: R 20/____ L 20/ ____ Corrected: Y / N Contacts: Y / N Glasses: Y /
Hearing : R_____L_____

	Normal	Abnormal Findings	Comments
Head/Neck			
Eyes/Sclera/Pupils			
Ears			
Nose/Mouth/Throat			
Heart: **Murmurs/Rhythms**			
Lungs: **Auscultation/Percussion**			
Chest Contour			
Skin			
Abdomen: **Assessment (inc. liver, spleen)**			
Tanner Stage: **Testes/Onset of Menses:**			
Hernia	**No**	**Yes/Possible**	
Neck/Back/Spine: **Range of Motion:**			
Scoliosis:			
Upper Extremities			
Lower Extremities			
Neurological: **Balance & Coordination:** **Romberg:**			
Heel Walk:			
Tandem Walk:			
Nose Touch:			
Toe Walk:			

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ALLERGIES:
Medications currently in use:
Additional Observations:
Any defect of vision, hearing or speech that the school could compensate for by proper seating, etc.? Any condition limiting classroom activity or physical education? Any condition which may result in a classroom emergency? Any emotional, mental or physical condition requiring periodic medical observation.?

Immunizations

DPT _____ _____ _____ _____ _____ _____

POLIO _____ _____ _____ _____ _____
(indicate OPV OR IPV)

MMR _____ _____

HIB _____ _____ _____ _____

Hepatitis B _____ _____ _____

Varivax _____ **PCV (pneumococcal vaccine)** _____ _____ _____

Other (specify) _____

TB Screening _____ _____

(Mantoux Test) date **result**

Physician: _____ **Phone:** _____ **Fax:** _____

Address: _____ **City/State/Zip:** _____

EXAMINED BY: Physician's/Provider's Stamp:

Family Physician/Provider_____

____MD____DO____NP____PA

***PHYSICIAN'S/PROVIDER'S SIGNATURE*:**_____

_____

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Family Physician/Provider_____

____MD____DO____NP____PA

***PHYSICIAN'S/PROVIDER'S SIGNATURE*:**_____

_____
