New Jersey Department of Education
ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Part A: HEALTH HISTORY QUESTIONNAIRE-Completed by the parent and student and reviewed by examining provider
Part B: PHYSICAL EVALUATION FORM-Completed by examining licensed provider with MD, DO, APN or PA

Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date:_____ **Date of Last Sports Physical:** _____

Student's Name: _____ Sex: M F (circle one) Age: ____ Grade: _____

Date of Birth: ____/___/_____ School: _____ District: _____

Sport(s): _____ Home Phone: (_____) _____

Provider Name (Medical Home): _____ Phone: _____ Fax: _____

EMERGENCY CONTACT INFORMATION

Name of parent/guardian: _____ Relationship to student: _____

Phone (work): _____ Phone (home):_____ Phone (cell): _____

Additional emergency contact: _____ Relationship to student: _____

Phone (work): _____ Phone (home):_____ Phone (cell): _____

Directions: Please answer the following questions about the student's medical history by **CIRCLING** the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. **Have you ever had, or do you currently have:**
   - a. Restriction from sports for a health related problem? Y / N / Don't Know
   - b. An injury or illness since your last exam? Y / N / Don't Know
   - c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don't Know
     - (1.) An inhaler or other prescription medicine to control asthma? Y / N / Don't Know
   - d. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don't Know
   - e. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't Know
   - f. Any **allergies** to medications? **Y / N / Don't Know**
   - g. Any allergies to bee stings, pollen, latex or foods? Y / N / Don't Know
     - (1.) If yes, check type of reaction:

       ☐ Rash ☐ Hives ☐ Breathing or other anaphylactic reaction
     - (2.) Take any medication/Epipen taken for allergy symptoms? (List below.) Y / N / Don't Know
   - h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don't Know
   - i. A blood relative who died before age 50? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

_____
_____
_____
_____
_____

List all medications here:

Medication Name	Dosage	Frequency

2. **Have you ever had, or do you currently have, any of the following *head-related* conditions:**

a. Concussion or head injury (including "bell rung" or a "ding")?	Y / N / Don't Know
b. Memory loss?	Y / N / Don't Know
c. Knocked out?	Y / N / Don't Know
c. A seizure?	Y / N / Don't Know
d. Frequent or severe headaches (With or without exercise)?	Y / N / Don't Know
e. Fuzzy or blurry vision	Y / N / Don't Know
f. Sensitivity to light/noise	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

_____

_____

_____

3. **Have you ever had, or do you currently have, any of the following *heart-related* conditions:**

a. Restriction from sports for heart problems?	Y / N / Don't Know
b. Chest pain or discomfort?	Y / N / Don't Know
c. Heart murmur?	Y / N / Don't Know
d. High blood pressure?	Y / N / Don't Know
e. Elevated cholesterol level?	Y / N / Don't Know
f. Heart infection?	Y / N / Don't Know
g. Dizziness or passing out during or after exercise without known cause?	Y / N / Don't Know
h. Has a provider ever ordered a heart test (EKG, echocardiogram, stress test, Holter monitor)?	Y / N / Don't Know
i. Racing or skipped heartbeats?	Y / N / Don't Know
j. Unexplained difficulty breathing or fatigue during exercise?	Y / N / Don't Know
k. Any family member (blood relative):	
(1.) Under age 50 with a heart condition?	Y / N / Don't Know
(2.) With Marfan Syndrome?	Y / N / Don't Know
(3.) Died of a heart problem before age 50? If yes, at what age? _____	Y / N / Don't Know
(4.) Died with no known reason?	Y / N / Don't Know
(5.) Died while exercising? If yes, was it during or after? (Circle one.)	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

_____

_____

_____

4. **Have you ever had, or do you currently have, any of the following *eye, ear, nose, mouth or throat conditions:***

a. Vision problems?	Y / N / Don't Know
(1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.)	Y / N / Don't Know
b. Hearing loss or problems?	Y / N / Don't Know
(1.) Wear hearing aides or implants?	Y / N / Don't Know
c. Nasal fractures or frequent nose bleeds?	Y / N / Don't Know
d. Wear braces, retainer or protective mouth gear?	Y / N / Don't Know
e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)?	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

_____

_____

_____

5. **Have you ever had, or do you currently have, any of the following *neuromuscular/orthopedic conditions*:**

a. Numbness, a "burner", "stinger" or pinched nerve?	Y / N / Don't Know
b. A sprain?	Y / N / Don't Know
c. A strain?	Y / N / Don't Know
d. Swelling or pain in muscles, tendons, bones or joints?	Y / N / Don't Know
e. Dislocated joint(s)?	Y / N / Don't Know
f. Upper or lower back pain?	Y / N / Don't Know
g. Fracture(s), stress fracture(s), or broken bone(s)?	Y / N / Don't Know
h. Do you wear any protective braces or equipment?	Y / N / Don't Know

Explain all (yes) answers here (include relevant dates):

_____

_____

_____

6. **Have you ever had or do you currently have any of the following *general or exercise related conditions*:**

a. Difficulty breathing?	
(1.) During exercise?	Y / N / Don't Know
(2.) After running one mile?	Y / N / Don't Know
(3.) Coughing, wheezing or shortness of breath in weather changes?	Y / N / Don't Know
(4.) Exercise-induced asthma?	Y / N / Don't Know
i. Controlled with medication? (specify _____)	Y / N / Don't Know
ii. Experience dizziness, passing out or fainting?	Y / N / Don't Know
b. Viral infections (e.g. mono, hepatitis, coxsackie virus)?	Y / N / Don't Know
c. Become tired more quickly than others?	Y / N / Don't Know
d. Any of the following skin conditions:	
(1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts?	Y / N / Don't Know
(2.) Sun sensitivity?	Y / N / Don't Know
e. Weight gain/loss (of 10 pounds or more)?	Y / N / Don't Know
(1.) Do you want to weigh more or less than you do now?	Y / N / Don't Know
f. Ever had feelings of depression?	Y / N / Don't Know
g. Heat-related problems (dehydration, dizziness, fatigue, headache)?	Y / N / Don't Know
(1.) Heat exhaustion (cool, clammy, damp skin)?	Y / N / Don't Know
(2.) Heat stroke (hot, red, dry skin)?	Y / N / Don't Know
(3.) Muscle cramps?	Y / N / Don't Know
h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)?	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

_____
_____
_____

7. **Females only:**

Age of onset of menstruation:_____ How many menstrual periods in the last twelve (12) months? _____

How many periods missed in the last twelve (12) months? _____

8. **Males only:**

Have you had any swelling or pain in your testicles or groin? Y / N / Don't Know

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

_____ _____

Signature, Parent/Guardian or Student Age 18 Date of Signature:

THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.

ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

Part B: Physical Evaluation Form

(Completed by the examining licensed provider MD, DO, APN or PA)

-STUDENT INFORMATION-

Student's Name: _____ Sport(s): _____

Sex: M F (circle one) Age: _____ Grade: _____ Date of Birth: _____

Address: _____

City/State/Zip:_____ Home Phone: _____

School: _____ District: _____

Parent/Guardian's Full Name: _____

- EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION-

If conducted by school physician check here ☐

Name: _____ Phone: _____ Fax: _____

Address:_____ City/State/Zip:_____

- FINDINGS OF PHYSICAL EVALUATION -

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____bpm.

Vision: R 20/____ L 20/ ____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head/Neck	YES	
Eyes/Sclera/Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose/Mouth/Throat	YES	
Lymph Glands	YES	
Cardiovascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
If murmur present		Standing makes it: Louder Softer No Change
		Squatting makes it: Louder Softer No Change
		Valsalva makes it: Louder Softer No Change
Femoral Pulses	YES	
Lungs: Auscultation/Percussion	YES	
Chest Contour	YES	
Skin	YES	
Abdomen (liver, spleen, masses)	YES	
Assessment of physical maturation or Tanner Scale	YES	
Testicular Exam (Males Only)	YES	
Neck/Back/Spine:	YES	
Range of Motion	YES	
Scoliosis	ABSENT	
Upper Extremities: (ROM, Strength, Stability)	YES	
Lower Extremities: (ROM, Strength, Stability)	YES	
Neurological: Balance & Coordination	YES	
Hernia	ABSENT	
Evidence of Marfan Syndrome	ABSENT	

Most recent immunizations and dates administered:

_____
_____
_____

Medications currently prescribed, with dose and frequency:

Medication Name	Dosage	Frequency

Additional observations:

_____
_____
_____
_____

General Diagnosis: _____
_____
_____

General Recommendations:

_____
_____

THE HISTORY PREPARED BY THE PARENT/STUDENT MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE PHYSICAL EXAMINATION.

CLEARANCES: This section is completed by the examining healthcare provider.

After examining the student and reviewing the medical history the student is:

☐ **A.** **Cleared** for participation in **all** sports without restrictions.

☐ **B.** **Not cleared** for participation in **any** sport until evaluation/treatment of:

_____

☐ **C.** **Cleared for limited participation** in the following types of sports only. Please see below for sport classifications. CHECK ALL THAT APPLY

___ CONTACT/COLLISION
___ LIMITED CONTACT
___ NON-CONTACT/STRENUOUS
___ NON-CONTACT/NON-STRENUOUS

Limitations due to: _____

NOTES TO THE EXAMINING PROVIDER

Conditions requiring clearance before sports participation include, but are not limited to the following:

Anaphylaxis; Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; Seizure Disorder; Marfan's Syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Basketball	Baseball	Discus	Bowling
Diving	Cheerleading	Javelin	Golf
Field Hockey	Fencing	Shot put	
Football	High Jump	Rowing	
Ice Hockey	Pole vault	Running/Cross Country	
Lacrosse	Gymnastics	Strength Training	
Soccer	Skiing	Swimming	
Wrestling	Softball	Tennis	
	Volleyball	Track	

Effects of physiologic maneuvers on heart sounds

Standing	Increases murmur of HCM Decreases murmur of AS, MR MVP click occurs earlier in systole
Squatting	Increases murmur of AS, MR, AI Decreases murmur of MCH MVP click delayed
Valsalva	Increases murmur of HCM Decreases murmur of AS, MR MVP click occurs earlier in systole

HCM: Hypertrophic Cardio Myopathy
AS: Aortic Stenosis
AI: Aortic Insufficiency
MR: Mitral Regugitation
MVP: Mitral Valve Prolapse

Physical Stigmata of Marfan's Syndrome

Kyphosis
High arched palate
Pectus excavatum
Arachnodactyly
Arm span > height 1.05:1 or greater
Mitral Valve Prolapse
Aortic Insufficiency
Myopia
Lenticular dislocation

HISTORY REVIEWED AND STUDENT EXAMINED BY: Physician's/Provider's Stamp:

□ Primary Care Provider
□ School Physician Provider
□ License Type:
□ MD/DO
□ APN
□ PA

PHYSICIAN'S/PROVIDER'S SIGNATURE: _____

Today's Date: _____ Date of Exam: _____

RESERVED FOR SCHOOL DISTRICT USE

NOTE: *N.J.A.C. 6A:16-2.2* requires the school physician to provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this physical evaluation. This evaluation and the notification letter become part of the student's school health record.

History and Physical Reviewed By: _____ Date: _____

Title of Reviewer (please check one): □ School Nurse □ School Physician

Medical Eligibility Notification Sent to Parent/Guardian by School Physician _____
Date

□ Letter of notification is attached.

OR

Parent notification indicates that:

□ Participation Approved without limitations.

□ Participation Approved with limitations pending evaluation.

□ Participation NOT Approved

Reason(s) for Disapproval: _____

_____

MINIMAL IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
N.J.A.C. 8:57-4: Immunization of Pupils in School

DISEASE(S)	MEETS IMMUNIZATION REQUIREMENTS	COMMENTS
DTaP	(AGE 1-6 YEARS): 4 doses, with one dose given on or after the 4th birthday, OR any 5 doses. (AGE 7-9 YEARS): 3 doses of Td or any previously administered combination of DTP, DTaP, and DT to equal 3 doses.	Any child entering pre-school, pre-Kindergarten, or Kindergarten needs a minimum of four doses. Pupils after the seventh birthday should receive adult type Td. DTP/Hib vaccine and DTaP also valid DTP doses. Laboratory evidence of immunity is also acceptable.
Tdap	GRADE 6 *(or comparable age level for special education programs)*: 1 dose	For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. A child does not need a Tdap dose until FIVE years after the last DTP/DTaP or Td dose.
POLIO	(AGE 1-6 YEARS): 3 doses, with one dose given on or after the 4th birthday, OR any 4 doses. (AGE 7 or OLDER): Any 3 doses.	Either Inactivated Polio Vaccine (IPV) or Oral Polio Vaccine (OPV) separately or in combination is acceptable. Polio vaccine is not required of pupils 18 years of age or older. Laboratory evidence of immunity is also acceptable.
MEASLES	If born before 1-1-90, 1 dose of a live Measles-containing vaccine on or after the first birthday. If born on or after 1-1-90, 2 doses of a live Measles-containing vaccine on or after the first birthday. If entering a college or university after 9-1-95 and previously unvaccinated, 2 doses of a live Measles-containing vaccine on or after the first birthday.	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs a minimum of 1 dose of measles vaccine. Any child entering Kindergarten needs 2 doses. Previously unvaccinated students entering college after 9-1-95 need 2 doses of measles-containing vaccine or any combination containing live measles virus administered after 1968. Documentation of 2 prior doses is acceptable. Laboratory evidence of immunity is also acceptable. Intervals between first and second measles/MMR/MR doses cannot be less than 1 month.
RUBELLA and MUMPS	1 dose of live Mumps-containing vaccine on or after the first birthday. 1 dose of live Rubella-containing vaccine on or after the first birthday.	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs 1 dose of rubella and mumps vaccine. Any child entering Kindergarten needs 1 dose each. Each student entering college for the first time after 9-1-95 needs 1 dose of rubella and mumps vaccine or any combination containing live rubella and mumps virus administered after 1968. Laboratory evidence of immunity is also acceptable.
VARICELLA	1 dose on or after the first birthday.	All children 19 months of age and older enrolled into a child care/pre-school center after 9-1-04 or children born on or after 1-1-98 entering a school for the first time in Kindergarten or Grade 1 need 1 dose of varicella vaccine. Laboratory evidence of immunity, physician's statement or a parental statement of previous varicella disease is also acceptable.
HAEMOPHILUS INFLUENZAE B (Hib)	(AGE 2-11 MONTHS)[1]: 2 doses (AGE 12-59 MONTHS)[2]: 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten. [1] Minimum of 2 doses of Hib vaccine is needed if between the ages of 2-11 months. [2] Minimum of 1 dose of Hib vaccine is needed after the first birthday. DTP/Hib and Hib/Hep B also valid Hib doses.
HEPATITIS B	(K-GRADE 12): 3 doses or 2 doses [1]	[1] If a child is between 11-15 years of age and has not received 3 prior doses of Hepatitis B then the child is eligible to receive 2-dose Hepatitis B Adolescent formulation. Laboratory evidence of immunity is also acceptable.
PNEUMO-COCCAL	(AGE 2-11 MONTHS)[1]: 2 doses (AGE 12-59 MONTHS)[2]: 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten. [1] Minimum of 2 doses of Pneumococcal vaccine is needed if between the ages of 2-11 months. [2] Minimum of 1 dose of Pneumococcal vaccine is needed after the first birthday.
MENINGO-COCCAL	(Entering GRADE 6 *(or comparable age level for Special Ed programs)*: 1 dose [1] (Entering a four-year college or University, previously unvaccinated and residing in a campus dormitory): 1 dose [2]	[1] For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. [2] Previously unvaccinated students entering a four-year college or university after 9-1-04 and who reside in a campus dormitory, need 1 dose of meningococcal vaccine. Documentation of one prior dose is acceptable.
INFLUENZA	(AGES 6-59 MONTHS): 1 dose ANNUALLY	For children enrolled in child care, pre-school or pre-Kindergarten on or after 9-1-08. 1 dose to be given between September 1 and December 31 of each year.

AGE APPROPRIATE VACCINATIONS (FOR LICENSED CHILD CARE CENTERS/PRE-SCHOOLS)

CHILD'S AGE	NUMBER OF DOSES CHILD SHOULD HAVE (BY AGE):
2-3 Months	1 dose DTaP, 1 dose Polio, 1 dose Hib, 1 dose PCV7
4-5 Months	2 doses DTaP, 2 doses Polio, 2 doses Hib, 2 doses PCV7
6-7 Months	3 doses DTaP, 2 doses Polio, 2-3 doses Hib, 2-3 doses PCV7, 1 dose Influenza
8-11 Months	3 doses DTaP, 2 doses Polio, 2-3 doses Hib, 2-3 doses PCV7, 1 dose Influenza
12-14 Months	3 doses DTaP, 2 doses Polio, 1 dose Hib, 2-3 doses PCV7, 1 dose Influenza
15-17 Months	3 doses DTaP, 2 doses Polio, 1 dose MMR, 1 dose Hib, 1 dose PCV7, 1 dose Influenza
18 Months-4 Years	4 doses DTaP, 3 doses Polio, 1 dose MMR, 1 dose Hib, 1 dose Varicella, 1 dose PCV7, 1 dose Influenza

PROVISIONAL ADMISSION:

Provisional admission allows a child to enter/attend school but must have a minimum of one dose of each of the required vaccines. Pupils must be actively in the process of completing the series. If a pupil is <5 years of age, they have 17 months to complete the immunization requirements. If a pupil is 5 years of age and older, they have 12 months to complete the immunization requirements.

GRACE PERIODS:

- 4-day grace period: All vaccines doses administered less than or equal to four days before either the specified minimum age or dose spacing interval shall be counted as valid and shall not require revaccination in order to enter or remain in a school, pre-school or child care facility.
- 30-day grace period: Those children transferring into a New Jersey school, pre-school, or child care center from out of state/out of country may be allowed a 30-day grace period in order to obtain past immunization documentation before provisional status shall begin.

Vaccine Administration Record for Children and Teens

Patient name: _____

Birthdate: _____

Chart number: _____

Vaccine	Type of Vaccine[1] (generic abbreviation)	Date given (mo/day/yr)	Source (F,S,P)[2]	Site[3]	Vaccine		Vaccine Information Statement		Signature/ initials of vaccinator
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Hepatitis B[5] (e.g., HepB, Hib-HepB, DTaP-HepB-IPV) Give IM.									
Diphtheria, Tetanus, Pertussis[5] (e.g., DTaP, DTaP-Hib, DTaP-HepB-IPV, DT, Tdap, Td) Give IM.									
***Haemophilus influenzae* type b**[5] (e.g., Hib, Hib-HepB, DTaP-Hib) Give IM.									
Polio[5] (e.g., IPV, DTaP-HepB-IPV) Give IPV SC or IM. Give DTaP-HepB-IPV IM.									
Pneumococcal (e.g., PCV, conjugate; PPV, polysaccharide) Give PCV IM. Give PPV SC or IM.									
Rotavirus (Rv) Give oral (po).									
Measles, Mumps, Rubella[5] (e.g., MMR, MMRV) Give SC.									
Varicella[5] (e.g., Var, MMRV) Give SC.									
Hepatitis A (HepA) Give IM.									
Meningococcal (e.g., MCV4; MPSV4) Give MCV4 IM and MPSV4 SC.									
Human papillomavirus (e.g., HPV) Give IM.									
Influenza[5] (e.g., TIV, inactivated; LAIV, live attenuated) Give TIV IM. Give LAIV IN.									
Other									

1. Record the generic abbreviation for the type of vaccine given (e.g., DTaP-Hib, PCV), *not* the trade name.
2. Record the source of the vaccine given as either F (Federally-supported), S (State-supported), or P (supported by Private insurance or other Private funds).
3. Record the site where vaccine was administered as either RA (Right Arm), LA (Left Arm), RT (Right Thigh), LT (Left Thigh), IN (Intranasal), or O (Oral).
4. Record the publication date of each VIS as well as the date it is given to the patient.
5. For combination vaccines, fill in a row for each separate antigen in the combination.

Technical content reviewed by the Centers for Disease Control and Prevention, Nov. 2006.

www.immunize.org/catg.d/p2022b.pdf • Item #P2022 (11/06)

Vaccine Administration Record for Children and Teens

Patient name: Shawn Abler

Birthdate: February 3, 2006

Chart number: SA-4837

Vaccine	Type of Vaccine[1] (generic abbreviation)	Date given (mo/day/yr)	Source (F,S,P)[2]	Site[3]	Vaccine		Vaccine Information Statement		Signature/ initials of vaccinator
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Hepatitis B[5] (e.g., HepB, Hib-HepB, DTaP-HepB-IPV) Give IM.	HepB	2/03/06	S	RT	0651M	MRK	7/11/01	2/03/06	JTA
	Hib-HepB	4/03/06	S	RT	1051M	MRK	7/11/01	4/03/06	DCP
	Hib-HepB	6/05/06	S	RT	1051M	MRK	7/11/01	6/05/06	DCP
Diphtheria, Tetanus, Pertussis[5] (e.g., DTaP, DTaP-Hib, DTaP-HepB-IPV, DT, Tdap, Td) Give IM.	DTaP	4/03/06	S	RT	647A2	GSK	7/30/01	4/03/06	DCP
	DTaP	6/05/06	S	RT	647A2	GSK	7/30/01	6/05/06	DCP
***Haemophilus influenzae* type b**[5] (e.g., Hib, Hib-HepB, DTaP-Hib) Give IM.	Hib-HepB	4/03/06	S	RT	1051M	MRK	12/16/98	4/03/06	DCP
	Hib-HepB	6/05/06	S	RT	1051M	MRK	12/16/98	6/05/06	DCP
Polio[5] (e.g., IPV, DTaP-HepB-IPV) Give IPV SC or IM. Give DTaP-HepB-IPV IM.	IPV	4/03/06	S	LT	U4569-8	SPI	1/01/00	4/03/06	DCP
	IPV	6/05/06	S	LT	U4569-8	SPI	1/01/00	6/05/06	DCP
Pneumococcal (e.g., PCV, conjugate; PPV, polysaccharide) Give PCV IM. Give PPV SC or IM.	PCV	4/03/06	S	LT	489-835	WYE	9/30/02	4/03/06	DCP
	PCV	6/05/06	S	RT	489-835	WYE	9/30/02	6/05/06	DCP
Rotavirus (Rv) Give oral (po).	Rv	4/03/06	P	Oral	0857M	MRK			DCP
	Rv	6/05/06	P	Oral	0857M	MRK	4/12/06	6/05/06	DCP
Measles, Mumps, Rubella[5] (e.g., MMR, MMRV) Give SC.									
Varicella[5] (e.g., Var, MMRV) Give SC.									
Hepatitis A (HepA) Give IM.									
Meningococcal (e.g., MCV4; MPSV4) Give MCV4 IM and MPSV4 SC.									
Human papillomavirus (e.g., HPV) Give IM.									
Influenza[5] (e.g., TIV, inactivated; LAIV, live attenuated) Give TIV IM. Give LAIV IN.									
Other									

Hib-HepB (Comvax)

1 shot, 2 different VIS dates

How to record Hib-HepB combination vaccine

Example #1

1. Record the generic abbreviation for the type of vaccine given (e.g., DTaP-Hib, PCV), *not* the trade name.
2. Record the source of the vaccine given as either F (Federally-supported), S (State-supported), or P (supported by Private insurance or other Private funds).
3. Record the site where vaccine was administered as either RA (Right Arm), LA (Left Arm), RT (Right Thigh), LT (Left Thigh), IN (Intranasal), or O (Oral).
4. Record the publication date of each VIS as well as the date it is given to the patient.
5. For combination vaccines, fill in a row for each separate antigen in the combination.

Vaccine Administration Record for Children and Teens

Patient name: Renee Schmidt

Birthdate: December 2, 2004

Chart number: 2345678

Vaccine	Type of Vaccine[1] (generic abbreviation)	Date given (mo/day/yr)	Source (F,S,P)[2]	Site[3]	Vaccine		Vaccine Information Statement		Signature/ initials of vaccinator
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Hepatitis B[5] (e.g., HepB, Hib-HepB, DTaP-HepB-IPV) Give IM.	HepB	12/02/04	F	RT	0651M	MRK	7/11/01	12/02/04	JTA
	DTaP-HepB-IPV	2/02/05	F	RT	635A2	GSK	7/11/01	2/02/05	DCP
	DTaP-HepB-IPV	4/02/05	F	RT	712A2	GSK	7/11/01	4/02/05	DCP
	DTaP-HepB-IPV	6/02/05	F	RT	712A2	GSK	7/11/01	06/02/05	DLW
Diphtheria, Tetanus, Pertussis[5] (e.g., DTaP, DTaP-Hib, DTaP-HepB-IPV, DT, Tdap, Td) Give IM.	DTaP-HepB-IPV	2/02/05	F	RT	635A2	GSK	7/30/01	2/02/05	DCP
	DTaP-HepB-IPV	4/02/05	F	RT	712A2	GSK	7/30/01	4/02/05	DCP
	DTaP-HepB-IPV	6/02/05	F	RT	712A2	GSK	7/30/01	6/02/05	DLW
	DTaP-Hib	3/02/06	F	RA	P0897AA	SPI	7/30/01	3/02/06	RLV
Haemophilus influenzae type b[5] (e.g., Hib, Hib-HepB, DTaP-Hib) Give IM.	Hib	2/02/05	F	LT	UA744AA	SPI	12/16/98	2/02/05	DCP
	Hib	4/02/05	F	LT	UA744AA	SPI	12/16/98	4/02/05	DCP
	Hib	6/02/05	F	LT	UA744AA	SPI	12/16/98	6/02/05	DLW
	DTaP-Hib	3/02/05	F	RA	7172AA	SPI	12/16/98	3/02/05	RLV
Polio[5] (e.g., IPV, DTaP-HepB-IPV) Give IPV SC or IM. Give DTaP-HepB-IPV IM.	DTaP-HepB-IPV	2/02/05	F	RT	635A2	GSK	1/01/00	2/02/05	DCP
	DTaP-HepB-IPV	4/02/05	F	RT	712A2	GSK	1/01/00	4/02/05	DCP
	DTaP-HepB-IPV	6/02/05	F	RT	712A2	GSK	1/01/00	6/02/05	DLW
Pneumococcal (e.g., PCV, conjugate; PPV, polysaccharide) Give PCV IM. Give PPV SC or IM.	PCV	2/02/05	F	LT	489-835	WYE	9/30/02	2/02/05	DCP
	PCV	4/02/05	F	RT	489-835	WYE	9/30/02	4/02/05	DCP
	PCV	6/02/05	F	LT	489-835	WYE	9/30/02	6/02/05	DLW
	PCV	3/02/06	F	LA	501-245	WYE	9/30/02	3/02/06	RLV
Rotavirus (Rv) Give oral (po).									
Measles, Mumps, Rubella[5] (e.g., MMR, MMRV) Give SC.	MMRV	12/02/05	P	RA	0857M	MRK	1/15/03	12/02/05	DLW
Varicella[5] (e.g., Var, MMRV) Give SC.	MMRV	12/02/05	P	LA	0857M	MRK	12/16/98	12/02/05	DLW
Hepatitis A (HepA) Give IM.	HepA	12/02/05	F	LA	0524L	MRK	8/04/04	12/02/05	MAT
	HepA	6/02/06	F	LA	0634K	MRK	3/21/06	6/02/06	MAT
Meningococcal (e.g., MCV4; MPSV4) Give MCV4 IM and MPSV4 SC.									
Human papillomavirus (e.g., HPV) Give IM.									
Influenza[5] (e.g., TIV, inactivated; LAIV, live attenuated) Give TIV IM. Give LAIV IN.	TIV	10/05/05	RA	F	U097543	SPI	7/18/06	10/05/05	JTA
	TIV	11/05/05	RA	F	U097543	SPI	10/20/05	11/05/05	DCP
Other									

DTaP-HepB-IPV (Pediarix)

DTaP-Hib (Trihibit)

1 shot, 2 lot #s

1 shot, 3 different VIS dates

MMRV (ProQuad)

How to record DTaP-HepB-IPV, MMRV, and DTaP-Hib combination vaccines

Example #2

1. Record the generic abbreviation for the type of vaccine given (e.g., DTaP-Hib, PCV), *not* the trade name.
2. Record the source of the vaccine given as either F (Federally-supported), S (State-supported), or P (supported by Private insurance or other Private funds).
3. Record the site where vaccine was administered as either RA (Right Arm), LA (Left Arm), RT (Right Thigh), LT (Left Thigh), IN (Intranasal), or O (Oral).
4. Record the publication date of each VIS as well as the date it is given to the patient.
5. For combination vaccines, fill in a row for each separate antigen in the combination.

Vaccine Administration Record for Children and Teens

Patient name: Jane Stamper
Birthdate: October 15, 1989
Chart number: 3456789

Vaccine	Type of Vaccine[1] (generic abbreviation)	Date given (mo/day/yr)	Source (F,S,P)[2]	Site[3]	Vaccine		Vaccine Information Statement		Signature/ initials of vaccinator
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Hepatitis B[5] (e.g., HepB, Hib-HepB, DTaP-HepB-IPV) Give IM.	~~HepB (1.0 ml)~~	6/02/02	P	RA	0651M	MRK	7/11/01	6/02/02	TAA
	~~HepB (1.0 ml)~~	1/02/03	P	RA	0651M	MRK	7/11/01	1/02/03	TAA
Diphtheria, Tetanus, Pertussis[5] (e.g., DTaP, DTaP-Hib, DTaP-HepB-IPV, DT, Tdap, Td) Give IM.	DTP	12/15/89	P	RT	326-912	LED	1/01/88	12/15/89	DCP
	DTP	2/15/90	P	RT	326-912	LED	1/01/88	2/15/90	DCP
	DTP	4/15/90	P	RT	326-912	LED	1/01/88	4/15/90	DLW
	DTP	4/15/91	P	RA	326-912	LED	1/01/88	4/15/91	RLV
	DTP	4/15/94	P	RA	326-912	LED	10/15/91	4/15/94	JTA
	Td	10/15/01	P	RA	467-854	WAL	6/10/04	10/15/01	PWS
***Haemophilus influenzae* type b**[5] (e.g., Hib, Hib-HepB, DTaP-Hib) Give IM.	Hib	12/15/89	P	LT	1492L	MRK	6/01/89	12/15/89	DCP
	Hib	2/15/90	P	LT	1492L	MRK	6/01/89	2/15/90	DCP
	Hib	10/15/90	P	LT	1492L	MRK	6/01/89	10/15/90	DLW
Polio[5] (e.g., IPV, DTaP-HepB-IPV) Give IPV SC or IM. Give DTaP-HepB-IPV IM.	OPV	12/15/89	P	Oral	0678A	LED	3/01/83	12/15/89	DCP
	OPV	2/15/90	P	Oral	0678A	LED	3/01/83	2/15/90	DCP
	OPV	4/15/91	P	Oral	0896A	LED	3/01/83	4/15/91	RLV
	OPV	4/15/94	P	Oral	0987A	LED	10/15/91	4/15/94	JTA
Pneumococcal (e.g., PCV, conjugate; PPV, polysaccharide) Give PCV IM. Give PPV SC or IM.									
Rotavirus (Rv) Give oral (po).									
Measles, Mumps, Rubella[5] (e.g., MMR, MMRV) Give SC.	MMR	1/15/91	P	RA	0857M	MRK	1/01/88	1/15/91	DLW
	MMR	10/15/01	P	LA	0946M	MRK	1/01/88	10/15/01	PWS
Varicella[5] (e.g., Var, MMRV) Give SC.	Var	10/15/01	P	LA	0799M	MRK	12/16/98	10/15/01	PWS
Hepatitis A (HepA) Give IM.									
Meningococcal (e.g., MCV4; MPSV4) Give MCV4 IM and MPSV4 SC.	MCV4	8/19/05	P	LA	U1766AA	SPI	4/4/05	8/19/05	DCP
Human papillomavirus (e.g., HPV) Give IM.	HPV	9/12/06	P	RA	0637F	MRK	9/6/06	9/12/06	MAT
	HPV	11/14/06	P	RA	0637F	MRK	9/5/06	11/14/06	MAT
Influenza[5] (e.g., TIV, inactivated; LAIV, live attenuated) Give TIV IM. Give LAIV IN.									
Other	Tdap	7/9/06	P	LA	C2454AA	SPI	9/22/05	7/9/06	MAT

2-dose adult HepB for adolescents

How to record adult HepB vaccine given to 11-15 year olds

1. Record the generic abbreviation for the type of vaccine given (e.g., DTaP-Hib, PCV), *not* the trade name.
2. Record the source of the vaccine given as either F (Federally-supported), S (State-supported), or P (supported by Private insurance or other Private funds).
3. Record the site where vaccine was administered as either RA (Right Arm), LA (Left Arm), RT (Right Thigh), LT (Left Thigh), IN (Intranasal), or O (Oral).
4. Record the publication date of each VIS as well as the date it is given to the patient.
5. For combination vaccines, fill in a row for each separate antigen in the combination.

WEST WINDSOR-PLAINBORO REGIONAL SCHOOL DISTRICT

505 Village Road West
P.O. Box 505
West Windsor, NJ 08550
Phone: (609) 716-5000
Fax: (609) 716-5012

TRANSFER OF STUDENT RECORDS

Date: _____

To Whom It May Concern:

Re: _____

Date of Birth: _____

Grade: _____

The student named above has recently enrolled in our district. Would you kindly forward all school, discipline, and medical records to us at your earliest convenience? Please include results of standardized group and individual tests, and any other information that will assist us in proper placement.

Sincerely,

Colleen O'Cone
Registrar

Previous School and Address:

_____
_____
_____

West Windsor-Plainsboro School:

_____
(add name of school)

Parent Authorization for Release:

_____
Signature

Please send records to the attention of <u>Guidance Department</u> at the appropriate school(s). See reverse side for addresses. Thank you.