

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
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	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)						Document below single antigen vaccine receipt, serology titers, or varicella disease history	
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 PAPILOMAVIRUS) ***							
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			
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																				
V I S I O N	With correction	R																		
		L																		
		BOTH																		
	Without correction	R																		
		L																		
		BOTH																		
	Muscle Balance																			

Color Perception	Date	Results																		
H E A R I N G	Date																			
	Sweep Check	R																		
		L																		

BIENNIAL SCOLIOSIS SCREENING (Beginning at Age 10)	Date	Date	Date	Date	Date
Referred for abnormal result	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

