



**Welcome to the Rumson School District, where we aim to ignite students potential!**

In this packet you will find the following forms:

1. Cover Letter
- 1a. Summer Placement Testing Notice
2. Student Registration Form
3. Residency Statement (2 pages)
4. Release of Records Home Language Survey
5. Home Language Survey
6. Homeless Information
7. Transportation Request Form
8. New Student Interest Inventory
9. Parent Questionnaire
10. General Health Information
11. Individual Health Information for the School Nurse
- 11a. Health Exam Form - Pre-K – 5 / 6-8 no athletic participation
- 11b. Health Exam Form - Gr. 6-8 athletic participation
- 12a. Preschool Immunization information
- 12b. Gr. K-12 Immunization information
13. TB Program in Schools

All forms are to be returned with appropriate documentation to your child's respective school:

For Deane-Porter (PreK-3) return/contact: Secretary: Diane Ryan - 732-842-0330  
Nurse: Krisanne Zajac – 732-842-0330 x353

For Forrestdale (4-8) return/contact: Secretary: Ann Zimbile – 732-842-0383  
Nurse: Maria Montanez - 732-842-0383 x318

You will need to show proof of age from the list below upon registration:

- Religious, hospital, or physician's certification showing date of birth
- Entry into a family bible
- Adoption record
- Affidavit from a parent
- Birth certificate
- Previously verified school records
- None of these documents have to be US-based

All other documentation needed is indicated on the associated forms enclosed.

**Thank you! We look forward to having you as part of our Rumson School District family!**



## FORRESTDALE SCHOOL

60 Forrest Avenue, Rumson NJ 07760 732.842.0383/Fax 732.219.9458

Office of Curriculum  
Mrs. Vera Ridoux

Dear Parent(s)/Guardian(s),

Welcome to the Rumson School District! We are extremely happy you will be a part of the Bulldog family. As part of the admissions process, we examine each child's academic performance from prior schooling, both to provide the most accurate picture of your son or daughter as a learner, and to determine the appropriate placement in our district's programs. When reviewing the transferred file we are most interested in examining the following:

Lexile Level, Math Quantile level, Cognitive Performance, Standardized State Testing

Please contact your child's prior school to request that the records they forward to Rumson contain the information above if available. Should your child's records not include such information, we require participation in placement testing prior to the start of the school year. Below you will find the required assessments your child will participate in based on grade level.

**Entering Grades 3, 4, 5** - Cognitive Profile (entering Grade 3 only), Scholastic Reading Inventory, Scholastic Math Inventory,

**Entering Grades 6, 7, 8** - Scholastic Reading Inventory, Scholastic Math Inventory,

Without this information your child's placement may need to be changed after the school year begins as placement data will be collected after the start of school.

You will be notified separately when placement testing will be held. There is nothing your child needs to do in order to prepare for testing, outside of getting a good night's rest and eating a healthy breakfast. Students may bring a peanut-free snack and drink with them to testing. No calculators are permitted during testing.

Please feel free to reach out with any questions to your building principal:

Deane Porter School - Ms. Shari Feeney, 732-842-0330 x350

Forrestdale School - Mrs. Jennifer Gibbons, 732-842-0383 x314

Or the Curriculum Office - 732-945-3100.

Sincerely,

Vera Ridoux

District Supervisor of Curriculum, Instruction and Assessment

**RUMSON PUBLIC SCHOOLS**  
**Student Registration Form**

Student's name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Date of birth: \_\_\_\_\_ City, State and Country of Birth: \_\_\_\_\_

\*Proof of birth date as listed below

Circle ethnicity:      Hispanic      White      Black      Am. Indian/Alaskan      Asian      Hawaiian/Pacific Islander

Grade level: \_\_\_\_\_ Circle gender:      Female      Male

Is your home language English? ☐ Yes ☐ No

If no, what is your primary home language? \_\_\_\_\_

Parent/Guardian 1 name: \_\_\_\_\_

Parent/Guardian 1 address: \_\_\_\_\_

Parent/Guardian 1 e-mail address: \_\_\_\_\_

Parent/Guardian 2 name: \_\_\_\_\_

Parent/Guardian 2 address: \_\_\_\_\_

Parent/Guardian 2 e-mail address: \_\_\_\_\_

Phone numbers in order of contact preference. Please check type for each:

1. \_\_\_\_\_ ☐ parent 1 cell ☐ parent 2 cell ☐ home ☐ parent 1 work ☐ parent 2 work
2. \_\_\_\_\_ ☐ parent 1 cell ☐ parent 2 cell ☐ home ☐ parent 1 work ☐ parent 2 work
3. \_\_\_\_\_ ☐ parent 1 cell ☐ parent 2 cell ☐ home ☐ parent 1 work ☐ parent 2 work
4. \_\_\_\_\_ ☐ parent 1 cell ☐ parent 2 cell ☐ home ☐ parent 1 work ☐ parent 2 work

The Rumson School District Student, Parent, Staff Handbook is available online at [www.rumsonschool.org](http://www.rumsonschool.org). This handbook includes the district School Calendar, School Bell Schedule and all pertinent policies and procedures, including the acceptable use policies regarding technology, utilized by the district. Please initial here to indicate you have accessed the handbook and understand that students and parents are responsible for knowing the applicable content:

**Parent initials here:** \_\_\_\_\_

During the course of the school year, your child's photo may be taken for use in school publications. Do you grant permission for your child's photo to appear in these publications?

**Check your preference after reading all options.**☐ Yes      ☐ Yearbook only      ☐ No publications, including yearbook



During the course of the school year, your child's class may visit a nearby area of educational interest within walking distance of the school. Do you grant permission for your child to accompany his/her class on a walking trip?

**Check your answer:**

- ☐ Yes                      ☐ No

**I give the district permission to provide my contact information to the:**

- ☐ Rumson Education Foundation (REF) and/or
- ☐ Rumson Parent Teacher Organization (PTO) inclusive of the following: **(check all that apply)**
- ☐ Name
- ☐ Address
- ☐ Parent Email
- ☐ Parent Phone

### **Proof of Age**

Please provide documentation to show that your child falls within the school district's minimum and maximum age requirements. School districts typically accept a variety of documents for this purpose, such as religious, hospital, or physician's certificate showing date of birth; an entry in a family bible; an adoption record; an affidavit from parent; a birth certificate; or previously verified school records.

### **Student eligibility and enrollment**

The Board shall operate the schools of this district for the benefit of children between the ages of five (by Oct. 30th) and fifteen, resident in the District and eligible for attendance free of charge pursuant to NJAC 6A:23-3.1 et seq. in the schools of this district and such others as may be admitted, pursuant to statute and the policy of the Board.

### **Students entering the district**

If the child or children are nonresidents of Rumson Borough at the time of registration, the Superintendent of Schools must be furnished with a copy of a signed contract to buy, build or rent a home which will include the projected date of residency pursuant to Board Policy 5111.

Until actual residence takes place and proof has been submitted, a nonrefundable monthly tuition fee (1/10 of the per pupil cost) will be assessed for a one year period. If after a year actual residence has not taken place, the nonresident student is subject to removal from the school district or may apply as a tuition student based upon school policy and regulations

Tuition for all nonresident students will be paid monthly, one month in advance. The Board Secretary's office will be responsible for collection.

### **Students leaving the district**

Children of parents no longer residing in Rumson Borough during the school year may complete that school year providing:

- A. There is no cost for transportation involving the Rumson school district.
- B. A prepaid prorated tuition is paid to the Board of Education from 30 days after residence in Rumson Borough terminates; except no tuition shall be charged when residency is terminated after May 1.
- C. No tuition will be charged for students in 8<sup>th</sup> grade when residence is terminated after December 31.



**Certification of eligibility and enrollment**

Choose the **one** option that applies to your child's enrollment. Your signature also certifies information you completed on the front side (p.1) of this form.

Student's full name \_\_\_\_\_

1. I certify that my child resides and is domiciled in the Borough of Rumson.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

2. I certify that my child will reside and will be domiciled in the Borough of Rumson as of this date: \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

3. I certify that my child has been approved by the Rumson Board of Education as a tuition student.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**RESIDENCY STATEMENT**

**Your address is:** \_\_\_\_\_

The students(s) residing with you:

NAME(S) (Please print)	AGE	CURRENT GRADE / SCHOOL YEAR	SCHOOL OF ATTENDANCE

**COPIES ONLY** of at least **two** of the following documentation **are required:**

**(Additional documents may be requested)**

1. \_\_\_\_ Property tax bills, deeds, contracts of sale, leases, mortgages, signed letter from landlord
2. \_\_\_\_ Voter registration, licenses, permits, financial account information, utility bills
3. \_\_\_\_ Court orders, state agency agreements
4. \_\_\_\_ Receipts, bills, cancelled checks, insurance claims or payments
5. \_\_\_\_ Medical reports, social worker assessments, employment documents
6. \_\_\_\_ Affidavits, sworn statements
7. \_\_\_\_ Documents pertaining to military status and assignment
8. \_\_\_\_ Documents issued by a governmental entity
9. \_\_\_\_ Other evidence may be submitted to and reviewed in its totality as proof of residency  
(To be approved by the Chief School Administrator)

**AND, if applicable:**

10. A current signed and notarized affidavit (page 2) stating that the student(s) listed above resides with you and is financially dependent upon you even though you are not his/her parent or legal guardian. (Documentation of financial dependency must be attached, i.e., IRS return showing student as dependent.)



(REGISTRATION STATEMENT (continued...))

**AFFIDAVIT**

I, \_\_\_\_\_ affirm that I am the:  
(*print name*)

(check one) ☐ natural parent or legal guardian

☐ affidavit host

of the student(s) listed above. I further state that this form and the attached documentation constitute true and accurate proof that the student(s) listed above resides with me within the Borough of Rumson and will continue to do so for at least the next twelve consecutive months. If any student listed above stops living with me, or if I move my residence out of the Borough of Rumson, within that twelve month period, I will promptly notify the Rumson Board of Education in writing. Please note, residence includes that the child is domiciled at the Rumson residence listed on this form.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are false, I am subject to punitive action.

**Signed:** \_\_\_\_\_

**Dated:** \_\_\_\_\_

**Notarized:** \_\_\_\_\_





## BOARD OF EDUCATION OF THE BOROUGH OF RUMSON

60 Forrest Avenue, Rumson NJ 07760 732. 732.842.4747/Fax 732.842.4877

### Records Release Authorization Student Entering Forrestdale School

Student's Name: \_\_\_\_\_ Date of Request: \_\_\_\_\_

Current Grade: \_\_\_\_\_ Grade Entering ☐ Deane-Porter ☐ Forrestdale: \_\_\_\_\_Records to be released:

- Educational
- Remedial & Preventative Program
- Special Education
- Health (If transferring within NJ, please send original health card.)

Please forward records to:

Student Records  
Forrestdale School  
60 Forrest Avenue  
Rumson, NJ 07760

Or: Student Records  
Deane-Porter School  
50 Black Point Road  
Rumson, NJ 07760

I hereby grant permission for the release of the above records from:

Old school name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Number of years attended: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Please indicate below any other previous schools your child has attended and length of attendance:

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Note: As per New Jersey State Law 6:3-2.8, upon graduation or permanent departure of a pupil from the school system, the parent or adult pupil shall be notified in writing that a copy of the entire record will be provided to them upon request.

The following statements are guides of action for the employees of the Rumson School District in handling student records of departing students:

1. Mandated pupil records shall be forwarded to the receiving district with written notification to the parent or adult pupil.
2. Permitted records shall be forwarded to the receiving district only with the written consent of the parent or adult pupil except where a formal sending-receiving relationship exists between the school districts.
3. All records to be forwarded shall be sent to the administrative official of the school to which the pupil has transferred within ten days after the transfer has been verified by the requesting school district.
4. Parents or adult pupil shall be permitted to inspect and review and appeal any education records related to the pupil which are collected, maintained or used by the school district under these regulations (NJAC 6:28-1.10).

Legal reference: NJAC 6:3-2.6, 6:28-1.1, 6:2-3.8; Policy Sections 5119, 5125





# INFORMATION FOR PARENTS

Form #6



## IF YOUR FAMILY LIVES IN ANY OF THE FOLLOWING SITUATIONS:

In a shelter



In a motel or campground due to the lack of an alternative adequate accommodation



In a car, park, abandoned building, or bus or train station



Doubled up with other people due to loss of housing or economic hardship

*Your school-age children may qualify for certain rights and protections under the federal McKinney-Vento Act.*

### Your eligible children have the right to:

- Receive a free, appropriate public education.
- Enroll in school immediately, even if lacking documents normally required for enrollment.
- Enroll in school and attend classes while the school gathers needed documents.
- Enroll in the local school; or continue attending their school of origin (the school they attended when permanently housed or the school in which they were last enrolled), if that is your preference and is feasible.
  - \* If the school district believes that the school you select is not in the best interest of your children, then the district must provide you with a written explanation of its position and inform you of your right to appeal its decision.
- Receive transportation to and from the school of origin, if you request this.
- Receive educational services comparable to those provided to other students, according to your children's needs.

*If you believe your children may be eligible, contact the local liaison to find out what services and supports may be available. There also may be supports available for your preschool-age children.*



Local Liaison

Michael Snyder  
(732)842-0811

State Coordinator

Richard Wesler  
(732)695-7800 ext. 7805

If you need further assistance with your children's educational needs,  
contact the National Center for Homeless Education:

1-800-308-2145 \* [homeless@serve.org](mailto:homeless@serve.org) \* [www.serve.org/nche](http://www.serve.org/nche)



BOARD OF EDUCATION OF THE BOROUGH OF RUMSON

60 Forrest Avenue, Rumson NJ 07760 732.732.842.4747/Fax 732.842.4877

**STUDENT TRANSPORTATION REQUEST FORM****TO BE COMPLETED BY PARENT:**STUDENT NAME: \_\_\_\_\_  
Last Name First Name MI

DATE: \_\_\_\_\_

ATTENDING: ☐ Deane-Porter ☐ Forrestdale

GRADE: \_\_\_\_\_

DATE TRANSPORTATION TO BEGIN: \_\_\_\_\_

\*STREET ADDRESS: \_\_\_\_\_

DOB: \_\_\_\_\_

SEX: \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_  
\_\_\_\_\_

HOME PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

**\*Please note that not all students are transported. If it is determined that you are in the walking zone, you will be notified. Please wait for confirmation of route/stop assignment prior to boarding a bus.**

☐ I DO wish to request transportation:☐ I **DO NOT** wish to request transportation:\_\_\_\_\_  
Signature



## NEW STUDENT INTEREST INVENTORY

Name: \_\_\_\_\_ GRADE ENTERING \_\_\_\_\_

Birthday: \_\_\_\_\_ EMAIL: \_\_\_\_\_

What town are you coming from? \_\_\_\_\_

What did you like BEST about your old school?

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Who was your best friend and what did you like to do together?

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Do you play sports? If so, list each one.

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Do play an instrument? If so, list each one.

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List any hobbies that you have. What do you like to do in your free time?  
(ride bike, read, build models, etc)

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What subject do you get the best grades?

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What subject is your least favorite?

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What are you most excited for at Deane-Porter / Forrestdale?

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BOARD OF EDUCATION OF THE BOROUGH OF RUMSON

60 Forrest Avenue, Rumson NJ 07760 732. 732.842.4747/Fax 732.842.4877

**PARENT QUESTIONNAIRE**

Name of Child \_\_\_\_\_ Grade Entering \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_

Number of Older Brothers \_\_\_\_\_ Number of Older Sisters \_\_\_\_\_

Number of Younger Brothers \_\_\_\_\_ Number of Younger Sisters \_\_\_\_\_

How would you describe your child's experiences in school?

Academically:

Socially:

What does your child like to do outside of school?

What else do you think is important for us to know about your child? Who does your child know at Forrestdale?



**Dear Parents/Guardians,**

Welcome to the Rumson School District. In order to meet the health care needs of our students, please see attached important information.

### **Physical Examination Documentation**

Proof of a completed physical are required for every enrolled student regardless of grade. Your primary health care provider must complete the new student examination within the year prior to enrollment. Pupils transferring into school district are allowed a thirty-day grace period in order to obtain a physical exam. The primary care MD can use our form (see attached) or a generic physical exam form. If your child is enrolling in 6<sup>th</sup>, 7<sup>th</sup>, or 8<sup>th</sup> grade and may be interested in trying out for a sport you can use the required NJ Department of Education Sports Physical as both entry exam and sports exam (see attached for specific information regarding Sports)

### **Tuberculosis Testing Documentation**

If a student is transferring from another country, please contact the school nurse or refer to the NJ State Dept. of Health website [http://www.state.nj.us/health/hivstdtb/documents/tb/school\\_mandate.pdf](http://www.state.nj.us/health/hivstdtb/documents/tb/school_mandate.pdf) for the most up to date information regarding TB testing.

### **Immunization Documentation**

Rumson School District requires proof of vaccinations for all students. A completed, up to date immunization record must be provided within 30 days of student start date. Your child's primary care physician or previous school district can provide this documentation. Once received and reviewed the school nurse will contact you if the information is not up to date. A list of local clinics will be provided upon request to get the mandatory vaccines.

### **Medication Administration**

Any students that require medication administration must provide a signed order from your health care provider, a parental consent and the medication in its original container. This policy includes over the counter medications, homeopathic as well as prescription medications. The medication administration form is attached form or download the form from [www.rumsonschool.org](http://www.rumsonschool.org) website. A standing order has been provided by our school physician for the administration of epinephrine and Benadryl as needed for undiagnosed allergic or anaphylaxis reaction. Asthma Action Plan, Food Allergy Action Plan, and Seizure Plan information are also available (see attached).

### **Emergency Cards**

A completed emergency card is imperative in case of an emergency. Please complete immediately and alert school nurse of any changes during the school year as needed.

Thank you for your cooperation. Please feel free to contact the school nurse if you have any questions.

Maria E. Montanez, R.N., M.S.N.  
Forrestdale School Nurse  
(732) 842-0383 ext. 318  
[mmontanez@rumsonschool.org](mailto:mmontanez@rumsonschool.org)

Krisanne Zajac, R.N., M.S.N.  
Deane Porter School Nurse  
732-842-0330 ext. 353  
[kzajac@rumsonschool.org](mailto:kzajac@rumsonschool.org)

**Sports Tryouts/Physicals**

Tryouts for girls' field hockey, boys and girls soccer and cross country will start on the second week of school. Winter sports include girls' and boys' basketball and the spring sports include girls' softball, boy's baseball, and track. Signups will be available in the 6<sup>th</sup>, 7<sup>th</sup> and 8<sup>th</sup> grade students. All students must have an up to date physical completed on the Department of Education forms. The physical is good for 1 full year. Blank physical forms are available on the [www.rumsonschool.org](http://www.rumsonschool.org) on the health services section under downloadable forms. Parents are required to complete the history information and have the physical form completed by the health care provider. If you are unable to obtain the physical prior to tryouts one can be provided by the school physician dates are provided prior to each season. Please contact the school nurse to request an appointment. All students with a physical on file with the school nurse that has been completed on the required forms will only need a "Health History Update" form completed by the parent. The update form will be reviewed and students that require additional clearance (i.e., orthopedic clearance for a post physical fracture) will be contacted to obtain the additional clearance. All clearance forms must be provided prior to student participating in tryouts.

As per the State of NJ the mandated forms are the only forms that can be accepted as proof of a completed sport physical. In addition there are forms that require review and signing by both parent and student to confirm receipt of information. Information on concussion and cardiac death in sports is available online or in the sports package. Any students missing the required forms will not be able to tryout.

**Food Allergy Action Plan**

Students with specific allergies may require an Allergy Action Plan that can include the administration of Benadryl and/ or EpiPen. An order with specific instructions needs to be completed by the health care provider on this specific form. This will be the order for the school year. The "Food Allergy Action Plan" form can be obtained from the school website at [www.rumsonschool.org](http://www.rumsonschool.org) on the health services section under downloadable forms. Students that are cleared by the primary health care provider to self-administer the EpiPen can be identified on the form under the dosage section.

**Asthma Action Plan**

Student with asthma who may need medication during the school day will require a signed "Asthma Action Plan" by the primary health care provider. This will be the order for the school year. The "Asthma Action Plan" form can be obtained from the school website at [www.rumsonschool.org](http://www.rumsonschool.org) on the health services section under downloadable forms. Students that are cleared by the primary health care provider to carry and self-administer the inhaler should be checked off on the form.

**Seizure Action Plan**

Students with seizures who may need medication during the school day will require a signed "Seizure Action Plan" by the primary health care provider. The "Seizure Action Plan" form can be obtained from the school website at [www.rumsonschool.org](http://www.rumsonschool.org) on the health services section under downloadable forms. This will be the order for the school year.





## BOARD OF EDUCATION OF THE BOROUGH OF RUMSON

60 Forrest Avenue, Rumson NJ 07760 732. 732.842.4747/Fax 732.842.4877

Student's Name: \_\_\_\_\_

Grade: \_\_\_\_\_

**Individual Health Information for the School Nurse:**

1. Has your child had chicken pox? ☐ Yes ☐ No Date: \_\_\_\_\_  
or chicken pox vaccine: Date: \_\_\_\_\_
2. Has your child had any hospitalization, accidents or serious illnesses within the past year? ☐ Yes ☐ No  
If yes, please elaborate \_\_\_\_\_  
\_\_\_\_\_
3. Is there any chronic condition or disease that I should be aware of that may limit your child's activities? ☐ Yes ☐ No  
If yes, please elaborate \_\_\_\_\_  
\_\_\_\_\_
4. Does your child have any known allergies? ☐ Yes ☐ No  
If yes, please elaborate \_\_\_\_\_  
\_\_\_\_\_
5. Does your child have any other medical or health problems I should be aware of? ☐ Yes ☐ No  
If yes, please elaborate \_\_\_\_\_  
\_\_\_\_\_
6. Will your child be on any medication that must be administered during school hours?  
☐ Yes ☐ No If yes, NAME OF MEDICATION \_\_\_\_\_

In accordance with the New Jersey Department of Education Guidelines for School Health and the Rumson Board of Education Policy on Administering Medications (Policy #5141.21).

**"No Prescription or over the counter medication will be administered without a written order from the student's physician or licensed prescriber and without a written request by parent or guardian for administration"**

All medications must be sent to the school in the original container accompanied by the physician's written request. This form will remain on file for the current school year>

\_\_\_\_\_  
Parent/Guardian Signature\_\_\_\_\_  
Phone



## BOARD OF EDUCATION OF THE BOROUGH OF RUMSON

60 Forrest Avenue, Rumson NJ 07760 732.732.842.4747/Fax 732.842.4877

### Rumson School District Health Examination Form

Student's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Significant or Past Illness or Injury: \_\_\_\_\_

Varicella Disease: \_\_\_\_\_

Allergies: \_\_\_\_\_

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 <i>* (If Td or DT, indicate in corner box)</i>							
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 PAPILLOMAVIRUS) ***							
OTHER							

**Examination:**

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_

Eyes: \_\_\_\_\_ Vision Tested? ☐ Yes ☐ No Wears Glasses? \_\_\_\_\_Ears: \_\_\_\_\_ Hearing Tested? ☐ Yes ☐ No

Respiratory \_\_\_\_\_ Cardiovascular \_\_\_\_\_

Liver \_\_\_\_\_ Spleen \_\_\_\_\_ Hernia \_\_\_\_\_

Musculo-Skeletal \_\_\_\_\_ Skin \_\_\_\_\_

Scoliosis Screening \_\_\_\_\_ Genitalia \_\_\_\_\_

Neurological \_\_\_\_\_ Urinalysis performed: ☐ Yes ☐ NoPresently taking medication? ☐ Yes ☐ No If yes, will this be taken during school? \_\_\_\_\_

If yes, please specify:

Restrictions in Physical Education? ☐ Yes ☐ No Comments \_\_\_\_\_Mantoux TB Test Given? ☐ Yes ☐ No Date \_\_\_\_\_ Results \_\_\_\_\_

Signature of Examining Physician \_\_\_\_\_ Date \_\_\_\_\_

Physician's Address \_\_\_\_\_ Phone \_\_\_\_\_



# PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

Form # 11b

*(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep copy of this form in the chart.)*

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines

☐ Pollens

☐ Food

☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an Inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

\_\_\_\_\_

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_



# **PREPARTICIPATION PHYSICAL EVALUATION** **THE ATHLETE WITH SPECIAL NEEDS:** **SUPPLEMENTAL HISTORY FORM**

Form # 11b continued

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

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Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_



**NOTE:** The preparticipation physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

# **PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM**

**Form # 11b continued**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

## **PHYSICIAN REMINDERS**

- Consider additional questions on more sensitive issues
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use chewing tobacco, snuff, or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP	/	( / )	Pulse Vision R 20/ L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</li> </ul>			
Eyes/ears/nose/throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>			
Lymph nodes			
Heart* <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, supine, +/- Valsalva)</li> <li>Location of point of maximal impulse (PMI)</li> </ul>			
Pulses <ul style="list-style-type: none"> <li>Simultaneous femoral and radial pulses</li> </ul>			
Lungs			
Abdomen			
Genitourinary (males only)*			
Skin <ul style="list-style-type: none"> <li>HSV, lesions suggestive of MRSA, linea corporis</li> </ul>			
Neurologic*			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional <ul style="list-style-type: none"> <li>Duck-walk, single leg hop</li> </ul>			

\*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  
 \*Consider GU exam if in private setting. Having third party present is recommended.  
 \*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- ☐ Cleared for all sports without restriction
- ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_
- ☐ Not cleared
- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports \_\_\_\_\_
- Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) \_\_\_\_\_ Date of exam \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician, APN, PA \_\_\_\_\_

# ■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Form # 11b continued

Name \_\_\_\_\_ Sex ☐ M ☐ F Age \_\_\_\_\_ Date of birth \_\_\_\_\_

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports \_\_\_\_\_

Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other information \_\_\_\_\_

### HCP OFFICE STAMP

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### SCHOOL PHYSICIAN:

Reviewed on _____
(Date)
Approved _____ Not Approved _____
Signature: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician, APN, PA \_\_\_\_\_

Completed Cardiac Assessment Professional Development Module

Date \_\_\_\_\_ Signature \_\_\_\_\_





# FOR CHILD CARE/PRESCHOOL DIRECTORS AND PARENTS: CHILD CARE/PRESCHOOL IMMUNIZATION REQUIREMENTS



## NJ Department of Health Vaccine Preventable Disease Program

New Jersey Minimum Immunization Requirements for Child Care/Preschool Attendance  
N.J.A.C. 8:57-4 Immunization of Pupils in School

Listed in the chart below are the minimum required number of doses your child must have in order to enroll/attend a child care/preschool facility in NJ. Additional vaccines are recommended by the Advisory Committee on Immunization Practices (ACIP), but only the following are required for child care/preschool attendance in NJ. For the complete ACIP Recommended Immunization Schedule, please visit <http://www.cdc.gov/vaccines/schedules/index.html>.

At this age the child should have received the following vaccines:	2 months	4 months	6 months	12 months	15 months	18 months	19 months	20-59 months
Diphtheria, tetanus & acellular pertussis (DTaP)	Dose #1	Dose #2	Dose #3			Dose #4		
Inactivated Poliovirus (Polio)	Dose #1	Dose #2				Dose #3		
<i>Haemophilus influenzae</i> type b (Hib)	Dose #1	Dose #2		1-4 doses (see footnote)		At least 1 dose given on or after the first birthday		
Pneumococcal conjugate (PCV 13)	Dose #1	Dose #2		1-4 doses (see footnote)	At least 1 dose given on or after the first birthday			
Measles, mumps, rubella (MMR)					Dose #1*			
Varicella (VAR)							Dose #1 <sup>‡</sup>	
Influenza (IIV; LAIV)								
					One dose due each year <sup>†</sup>			

**Interpretation:** Children need to receive the minimum number of age-appropriate vaccines prior to entering child care/preschool. For example, a child 2 months of age, must have 1 dose each of DTaP, Polio, Hib, and PCV before being permitted to enter child care/preschool. A child entering at a younger age range than listed above must have proof of receiving vaccines in the previous age bracket. Example: A child entering child care/preschool at 11 months of age, would need at least the following: 3 DTaP, 2 Polio, 2 Hib, and 2 PCV. The current seasonal flu vaccine is required every year by December 31 for children 6-59 months of age.





\* *Haemophilus influenzae* type b (Hib) and pneumococcal (PCV) vaccines are special cases. If a child started late with these vaccines he/she may need fewer doses. One dose of each is required on or after the first birthday in all cases.  
Please Note: The use of combination vaccines may allow students to receive the 1<sup>st</sup> birthday booster dose of Hib between 15-18 months of age.

† MMR vaccine may be given as early as 12 months of age, but NJ requires children to receive the vaccine by 15 months of age. Prior to age 15 months, a child may enter preschool/child care without a documented dose of MMR.

‡ Varicella vaccine may be given as early as 12 months of age, but NJ requires children to receive the vaccine by 19 months of age. Prior to age 19 months, a child may enter preschool/child care without a documented dose of varicella. A child will not have to receive the varicella vaccine if he/she previously had chickenpox as long as the parent can provide the school with one of the following: 1. Documented laboratory evidence showing immunity (protection) from chickenpox, 2. A physician's written statement that the child previously had chickenpox, or 3. A parent's written statement that the child previously had chickenpox.

¶ The current seasonal influenza vaccine is required every year for those children 6 months through 59 months of age. Students who have not received the flu vaccine by December 31 must be excluded (not allowed to attend child care/preschool) for the duration of influenza season (through March 31), until they receive at least one dose of the influenza vaccine or until they turn 60 months of age. Children enrolling in child care/preschool after December 31, must provide documentation of receiving the current seasonal flu vaccine before being allowed to enter school. Students enrolling in school after March 31 are not required to receive the flu vaccine; however, flu season may extend until May and therefore getting a flu vaccine even late in the season is still protective

NJ accepts valid medical and religious exemptions (reasons for not showing proof of immunizations) as per the NJ Immunization of Pupils in School regulations, N.J.A.C. 8:57-4. Children without proof of immunity as defined by ACIP, including those with medical and religious exemptions, may be excluded from a school, preschool, or child care facility during a vaccine preventable disease outbreak or threatened outbreak as determined by the Commissioner, Department of Health or his or her designee. In addition, anybody having control of a school may, on account of the prevalence of any communicable disease, or to prevent the spread of communicable disease, prohibit the attendance of any teacher or pupil of any school under their control and specify the time during which the teacher or scholar shall remain away from school. The Department of Health shall provide guidance to the school of the appropriateness of any such prohibition.

For more information, please visit "NJ Immunization Requirements Frequently Asked Questions", at the following link:  
<http://nj.gov/health/cd/imm.shtml>.

**Interpretation:** Children need to receive the minimum number of age-appropriate vaccines prior to entering child care/preschool. For example, a child 2 months of age, must have 1 dose each of DTaP, Polio, Hib, and PCV before being permitted to enter child care/preschool. A child entering at a younger age range than listed above must have proof of receiving vaccines in the previous age bracket. Example: A child entering child care/preschool at 11 months of age, would need at least the following: 3 DTaP, 2 Polio, 2 Hib, and 2 PCV. The current seasonal flu vaccine is required every year by December 31 for children 6-59 months of age.





## NJ Department of Health Vaccine Preventable Disease Program

New Jersey Minimum Immunization Requirements for Kindergarten-Grade 12 Attendance  
N.J.A.C. 8:57-4 Immunization of Pupils in School

### Guide for checking compliance

Step 1: Each child attending/enrolling must present documentation of immunizations or valid medical or religious exemption to vaccines. In order to allow a child to enter school, he/she must have at least one dose of each age-appropriate required vaccine.

Step 2: Determine child's present grade level.

Step 3: Compare the child's record with the requirements listed on the chart below.

Grade/level child enters school:	Minimum Number of Doses for Each Vaccine						
	DTaP Diphtheria, Tetanus, acellular Pertussis	Polio Inactivated Polio Vaccine (IPV)	MMR (Measles, Mumps, Rubella)	Varicella (Chickenpox)	Hepatitis B	Meningococcal	Tdap (Tetanus, diphtheria, acellular pertussis)
Kindergarten – 1 <sup>st</sup> grade	A total of 4 doses with one of these doses on or after the 4 <sup>th</sup> birthday OR any 5 doses*	A total of 3 doses with one of these doses given on or after the 4 <sup>th</sup> birthday. OR any 4 doses.	2 doses <sup>1</sup>	1 dose	3 doses	None	None
2 <sup>nd</sup> – 5 <sup>th</sup> grade	3 doses <i>NOTE: Children 7 years of age and older, who have not been previously vaccinated with the primary DTaP series, should receive 3 doses of Tetanus, diphtheria (Td)</i>	3 doses	2 doses	1 dose	3 doses	None	None
6 <sup>th</sup> grade and higher	3 doses	3 doses	2 doses	1 dose required for children born on or after 1/1/98 <sup>5</sup>	3 doses <sup>1</sup>	1 dose required for children born on or after 1/1/97 given <u>no earlier</u> than ten years of <u>age</u> <sup>2</sup>	1 dose required for children born on or after 1/1/97 **



Additional vaccines are recommended by the Centers for Disease Control and Prevention (CDC). The chart above lists only the vaccines that are required for school attendance in NJ. Please note that unvaccinated children, including those with medical and/or religious exemptions, may be excluded from school during a vaccine preventable disease outbreak or threatened outbreak to ensure public health safety.

For the complete CDC Recommended Immunization Schedule, please visit <http://www.cdc.gov/vaccines/schedules/index.html>.

\* **DTaP:** Children who previously attended child care/preschool should have received 4 doses since the requirement to receive the fourth birthday booster dose (5<sup>th</sup> dose) does not apply until the child attends Kindergarten. However, if one of these 4 doses was given after the 4<sup>th</sup> birthday, this child will not need an additional dose for Kindergarten. Children will need 5 doses if all doses were administered prior to the 4<sup>th</sup> birthday in order to enter Kindergarten.

**Polio:** Children who previously attended child care/preschool should have 3 doses since the requirement to receive the fourth birthday booster dose (4<sup>th</sup> dose) does not apply until the child attends Kindergarten. However, if one of these 3 doses was given after the 4<sup>th</sup> birthday, this child will not need an additional dose for Kindergarten. Children will need 4 doses if all doses were administered prior to the 4<sup>th</sup> birthday.

† A child is required to receive two doses of measles, one dose of mumps, and one dose of rubella once he/she enters Kindergarten. Since single antigen (separate components of the vaccine) is not readily available, most children will have two MMR vaccines.

The Antibody Titer Law (Holly's Law, NJSA 26:2N-8-11), passed on January 14, 2004, requires the New Jersey Department of Health (NJDOH) to accept serologic evidence of protective immunity to measles, mumps and rubella in lieu of the second ACIP recommended measles, mumps and rubella vaccine. For more information, please visit [http://nj.gov/health/cd/documents/antibody\\_titer\\_law.pdf](http://nj.gov/health/cd/documents/antibody_titer_law.pdf).

§ Varicella vaccine is only required for children born on or after January 1, 1998. A child will not have to receive the varicella vaccine if he/she previously had chickenpox as long as a parent can provide the school with one of the following: 1) Documented laboratory evidence showing immunity (protection) from chickenpox, 2) A physician's written statement that the child previously had chickenpox, or 3) A parent's written statement that the child previously had chickenpox.

† Two doses of hepatitis B vaccine is acceptable if child received the vaccine between 11 – 15 yrs. of age AND the vaccine is identified as Adolescent Formulation. Children who present documented laboratory evidence of hepatitis B disease or immunity, constituting a medical exemption, shall not be required to receive hepatitis B vaccine.

\*\* Tdap and Meningococcal vaccines are required for all entering 6<sup>th</sup> graders who are 11 years of age or older; 6<sup>th</sup> graders < 11 years must receive Tdap and meningococcal vaccines once age 11 is reached.

For the complete list of "NJ Immunization Requirements Frequently Asked Questions", please visit <http://nj.gov/health/cd/imm.shtml>.

## New Jersey Department of Health Tuberculosis Program

### Recommended Tuberculosis Testing in New Jersey Schools

Justification: To restrict tuberculosis screening in New Jersey schools to teachers/other employees and only those students who are at highest risk for latent TB infection.

- I. Only a positive interferon gamma release assay test result or a Mantoux intradermal test using 5 TU of stabilized PPD tuberculin skin test result measuring  $\geq 10$ mm of induration shall be considered a "significant reaction" and evidence of latent TB infection.
- II. The following tuberculosis testing recommendations apply to ALL school districts:
  1. Students born in a country that is not listed on page 3 and entering school in the U.S. for the first time, regardless of age or grade.
  2. Students transferring into the New Jersey school system directly from a country not listed on page 3, regardless of age or grade.

#### **EXCEPTIONS FOR BOTH GROUPS OF STUDENTS LISTED ABOVE:**

Entering at preschool through grade 5: Tuberculosis testing is not recommended if the student has documentation of an IGRA or Mantoux tuberculin skin test at the age of three years or older, regardless of the result of that test.

Entering at grades 6 through 12: Tuberculosis testing is not recommended if the student has documentation of a negative tuberculosis test in the last six months or a positive test, regardless when this test was done.

Tuberculosis testing is not recommended if the student has attended school in another state prior to entering the New Jersey school system.

Any student with parents claiming religious exemption (TB-8 Form) cannot be compelled to submit to tuberculosis testing. In these instances, a symptom assessment must be done (TB-8 Form). If TB-like symptoms are reported, a physician must document that the student does not have active disease. **Each school district is responsible for determining the criteria essential to document a valid religious exemption.**



### 3. Teachers and Other Employees

**A tuberculosis test shall be given upon employment to all newly hired employees (full-time and part-time), all student teachers, and school bus drivers on contract with the district and other persons (e.g., volunteers) who have contact with students.**

**EXEMPTIONS:**

Tuberculosis testing is not recommended for volunteers working with pupils for less than 20 hours per month.

Tuberculosis testing is not recommended for new employees, student teachers and contractors of the district with a documented negative tuberculosis test result in the last six months or a documented positive tuberculosis test, regardless of when this test was done.

Tuberculosis testing is not recommended for a school employee transferring between school districts or from a non-public school within New Jersey with a documented tuberculosis test result upon his/her initial employment by a New Jersey school.

Employees, student teachers, contractors or volunteers who have contact with students and claim religious exemption cannot be compelled to submit to tuberculosis testing. In these instances, a symptom assessment should be done (TB-8 Form). If TB-like symptoms are reported, a physician must document that the employee, student teacher, contractor or volunteer does not have active disease. **Each school district is responsible for determining the criteria essential to document a valid religious exemption.**



**THE FOLLOWING COUNTRIES HAVE A LOW INCIDENCE OF TB AND  
REQUIRE NO TB TESTING**

America Samoa	Lebanon
Andorra	Luxembourg
Antigua and Barbuda	Malta
Australia	Monaco
Austria	Montserrat
Barbados	Netherlands
Belgium	Netherlands Antilles
Bermuda	New Zealand
Canada	North Ireland
Cayman Islands	Norway
Cook Islands	Oman
Costa Rica	Puerto Rico
Cuba	Saint Kitts and Nevis
Cyprus	St. Lucia
Czech Republic	St. Maarten (Dutch)
Denmark	San Marino
Dominica	Slovakia
Finland	Slovenia
France	Spain
Germany	Sweden
Greece	Switzerland
Greenland	Trinidad and Tobago
Grenada	Turks and Caicos Islands
Iceland	United Arab Emirates
Ireland	United Kingdom of Great Britain and Northern Ireland
Israel	United States of America
Italy	United States Virgin Islands
Jamaica	West Bank and Gaza
Jordan	

**Students entering a U.S. school for the first time in New Jersey or transferring into a New Jersey school from ANY country NOT listed above must receive an IGRA or Mantoux tuberculin skin test unless they meet an exemption criterion.**