BRANCHBURG TOWNSHIP SCHOOLS
SCHOOL HEALTH SERVICES

REGISTRATION

Student Name_____

Date of Birth_____ Country of Birth_____

Documents *Required* by the Health Office:

_____**HEALTH HISTORY** (Branchburg Township Form)

_____**CURRENT Physical Examination** performed by the physician (9/6/2018 – 1st student day of school 2019)

REQUIRED Immunizations

_____ DTaP/DTP – 4 doses, with one dose given on or after the 4th birthday, OR any 5 doses

_____ Polio – 3 doses, with one dose given on or after the 4th birthday, OR any 4 doses

_____ Measles – 2 doses on or after the first birthday

_____ Rubella and Mumps – 1 dose of each, on or after the first birthday

_____ Varicella – 1 dose on or after the first birthday

_____ Hepatitis B – 3 doses

I have read and understand the requirements for my child to enter school. I understand that these documents must be presented to the school nurse no later than the first day of school, for my child to begin school.

_____ _____

Parent/Guardian Signature **Date**

_____

E-mail address

Thank you for your cooperation!

BRANCHBURG TOWNSHIP SCHOOLS
SCHOOL HEALTH SERVICES

PK-5 PHYSICAL EXAMINATION RECORD

-STUDENT INFORMATION-

Name: _____ Age: _____ Date of Birth: _____
Address: _____ City/State/Zip: _____ Home Phone: _____
School: _____Teacher:_____ Grade: _____ Gender: _____
Parent/Guardian's Full Name_____

-PHYSICIAN OR PROVIDER INFORMATION-

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____bpm.
Vision: R 20/____ L 20/ ____ Corrected: Y / N Contacts: Y / N Glasses: Y / N
Hearing: Right ear Normal @ 20dB_____ Left ear Normal @ 20dB_____

Indicators	Normal ? (Circle One)		Abnormal Findings/Comments
Head/Neck	YES	NO	
Eyes/Sclera/Pupils	YES	NO	
Ears	YES	NO	
Nose/Mouth/Throat	YES	NO	
Heart: Murmurs/Rhythms	YES	NO	
Lungs: Auscultation/Percussion	YES	NO	
Chest Contour	YES	NO	
Skin	YES	NO	
Abdomen: Assessment (includes liver, spleen)	YES	NO	
Tanner Stage: Testes/Onset of Menses:	YES	NO	
Neck/Back/Spine: **Range of Motion:**	YES YES	NO NO	
Scoliosis:	YES	NO	
Upper Extremities	YES	NO	
Lower Extremities	YES	NO	
Neurological: **Balance & Coordination:** **Romberg:**	 YES YES	 NO NO	
Heel Walk:	YES	NO	
Tandem Walk:	YES	NO	
Nose Touch:	YES	NO	
Toe Walk:	YES	NO	
Hernia? (If yes/possible, please explain)	YES/ Possible	NO	
Existing health conditions:			
Most recent Immunizations/Dates:			
Medications currently in use:			
Recommendations/Limitations/Further examination:			

General Health: _____good _____fair _____poor

EXAMINED BY:
Family Physician/Provider_____
School Physician_____

____MD____DO____NP____PA

Physician's/Provider's Stamp:

Physician's/Provider's Name:_____Phone:_____Fax:_____
Address:_____City/State/Zip:_____
Physician's/Provider's Signature:_____ Examination Date:_____

PLEASE ATTACH RECORD OF IMMUNIZATIONS TO PHYSICAL EXAMINATION RECORD

BRANCHBURG TOWNSHIP SCHOOLS
SCHOOL HEALTH SERVICES

HEALTH HISTORY

TO PARENTS/GUARDIANS:
Please provide the following information to help us understand the health status of your child.

Child's Name _____ _____ _____
Last First Middle

Date of Birth_____ Gender_____

Parent's Name_____ _____
Parent #1 Parent #2

Guardian(s)_____

Siblings (Name & Birth Date) Name Birth Date

_____ _____

_____ _____

_____ _____

Address:_____

Phone #_____

Last Physical Examination Date:_____

1. **Developmental History:** (Please indicate the age in months as accurately as possible)
   Creeping on all fours_____ Toilet Training_____
   Sitting Alone_____ Began to say single words_____
   Walking without assistance_____ Began to say phrases_____
   Feeding self_____ Began to say simple sentences_____

2. **Behavioral History:** (Check any of the following which your child exhibits frequently)
   Nervousness_____Daydreaming_____Nightmares_____Shyness_____
   Trouble Sleeping_____Temper Tantrums_____Walking in sleep_____
   Nail biting_____Frequent fear/tension_____Frequent fighting_____
   Frequent crying_____Thumb/finger sucking_____Seperation anxiety_____

   Additional comments:_____

3. **Medical History:** (Give approximate year or age):
   Asthma_____Diabetes_____Measles_____Bronchitis_____Seizures_____Rubella_____Pertussis_____
   Lyme Disease_____Mumps_____Pneumonia_____Eczema_____Chicken Pox_____Sinus Infections_____
   Encephalitis_____Gastrointestinal problems_____Strep Throat_____Meningitis_____
   Urinary tract problems_____Rheumatic Fever_____Mononucleosis_____

Additional Comments:_____

4. **Health Concerns**: (Please check any conditions pertaining to your child)
   Allergies (specify):
   Environmental _____Food_____
   Animal_____Insects_____
   Medications_____

   Headaches_____ Frequent Colds_____ Nosebleeds_____
   Mouth breathing_____ Snoring_____

   Ear symptoms:
   Discharge from ears_____ Turning head to hear _____ Asking to have things repeated _____
   Hearing aid(s) _____

   Speech:
   Stuttering_____ Lisp_____ Immature Speech (baby talk) _____

   Eye symptoms:
   Squinting _____Styes or crusted lids _____ Inflammation _____ Muscle problems _____
   Excessive blinking _____ **Wears glasses _____**

   Pain (frequent) Joints _____ Muscular _____ Other _____

5. Tuberculosis contacts? Yes _____ No _____

6. Has your child had any of the following? Give details:

   Serious Accidents:_____
   _____

   Hospitalizations:
   _____
   _____
   Surgery:_____
   _____

7. Is your child taking any medication? (If yes, please specify reason and type of medication)
   _____
   _____

8. Has your child had any preschool experience?
   Where_____
   When_____

I understand that state or federal law may prohibit the sharing of information contained in this form without prior approval of the parent or guardian. I hereby authorize the school nurse to share such information with teachers, aides, and administrators as may be required in her discretion to promote the health, safety, and general welfare of my child.

_____ _____
Signature Parent/Guardian Date

BRANCHBURG TOWNSHIP SCHOOLS
SCHOOL HEALTH SERVICES

REGISTRATION for PreK

Student Name_____

Date of Birth_____ Country of Birth_____

Documents *Required* by the Health Office:

_____**HEALTH HISTORY** (Branchburg Township Form)

_____**CURRENT Physical Examination** performed by the physician (9/6/2018 – 1st student day of school 2019)

REQUIRED Immunizations

_____ DTaP/DTP – 4 doses

_____ Polio – 3 doses

_____ Measles – 1 dose on or after the first birthday

_____ Rubella and Mumps – 1 dose of each, on or after the first birthday

_____ Varicella – 1 dose on or after the first birthday

_____ Haemophilus influenzae B (Hib) – 1 dose after the first birthday

_____Pneumococcal - 1 dose after the first birthday

_____Influenza* – 1 dose - between September 1 and December 31, of each pre-school year.

I have read and understand the requirements for my child to enter school. I understand that these documents must be presented to the school nurse no later than the first day of school, for my child to begin school.

***The influenza documentation will be presented to the nurse in the fall.**

_____ _____

Parent/Guardian Signature **Date**

_____

E-mail address

Thank you for your cooperation!

Branchburg School District
Student Transportation Department
580 Old York Road
Branchburg, NJ 08876

908-725-2895 Fax 908-575-1846
Robert Cline, Transportation Supervisor (bcline@branchburg.k12.nj.us)

Transportation Registration (Please print)

DATE: _____ NEW STUDENT _____ CHANGE OF ADDRESS_____

STUDENT'S LAST NAME:_____

FIRST NAME:_____MIDDLE NAME:_____

HOME ADDRESS:_____ZIP CODE:_____

HOME PHONE NUMBER:_____ _GENDER: M___F___

DATE OF BIRTH:_____ GRADE AS OF SEPTEMBER 2020: _____

SCHOOL STUDENT WILL BE ATTENDING:
Branchburg Central MS _____
Somerville High School _____
Stony Brook School _____
Whiton Elementary School _____

PARENT'S CONTACT INFORMATION OTHER THAN HOME PHONE NUMBER

PARENT #1:_____

Cell_____Work_____

PARENT #2:_____

Cell_____Work_____

EMERGENCY CONTACTS OTHER THAN PARENTS

NAME:_____ RELATIONSHIP_____

CELL / LANDLINE PHONE #_____
_____

OFFICE USE ONLY: STUDENT ID#_____