Aquinas Academy ✷ Saint Philomena

388 South Livingston Avenue • Livingston, New Jersey 07039 • 973-992-1587 • Fax: 973-992-4173

Email: mainoffice@aquinasacademynj.org Website: www.aquinasacademynj.org

Archdiocese of Newark
Parochial Schools

Health Requirements

Dear Parent/Guardian:

The Health Department requires that all new students and pupils in grades Kindergarten, Three and Six receive physical examinations. Your child's health is most important to us. Please ensure thoroughness by taking your child to your family physician this summer.

Your child's immunization records must be submitted to Aquinas Academy by September 1 of the academic year or your child will not be permitted to enter school.

Important note: As of September 1, 2004 the State of New Jersey requires every child born on or after January 1, 1998 to have received one dose of the varicella (chicken pox) vaccine before entering the school system (no earlier than their first birthday). This applies to all students entering preschool, K-Prep and kindergarten. Children whose physician or parents/guardians submit a statement of past history of varicella (chicken pox) disease, or serologic evidence of immunity will also be in compliance with the rules.

For your convenience, a physical examination form is attached.

Kindly,
School Nurse

Archdiocese of Newark
Parochial Schools
Livingston, New Jersey

Dental Health Requirements

Dear Parent/Guardian:

Aquinas Academy's health policy requires that all students receive an annual dental examination.

Your child's health is most important. Ensure thoroughness by taking your child to your family dentist on a regular basis.

For your convenience a dental examination form is typed below. Please submit to Aquinas Academy following the dental examination.

Thank you,
School Nurse

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Report of Dental Examination

Child's Name_______________________________________ Grade________________

School Aquinas Academy, 388 South Livingston Avenue, Livingston, New Jersey 07039

I have examined the above named child and he or she is currently under my care.

Dentist Signature____

Date of Examination ____

Please return signed dental form to school nurse as soon as possible following the exam.

Revised 08/2017

Name of Child _____ Date of Exam _____

Grade _____ Date of Birth _____

Height _____ Weight _____ Blood Pressure _____

Visual Acuity: Left Eye 20/_____ Right Eye 20/_____

Skin & Scalp _____ Hernia _____

Ears _____ Hearing _____ Lymph Nodes _____

Nose _____ Endocrine _____ Throat _____

Digestive Organs _____ Nutrition _____ Lungs _____

Nervous System _____ Speech Impediments _____ Heart _____

Feet _____ Scoliosis _____ Dentition _____

Other: _____

Positive Medical HX _____

_____

Immunization Record: (Month/Day/Year)

DPT 1._____ 2._____ 3._____ 4._____

Boosters _____

DT Booster _____ Tetanus Toxoid _____ Tdap _____

Sabin Oral Polio 1._____ 2._____ 3._____ 4._____

Boosters _____

MMR 1._____ 2._____ Mantoux Test _____
(type, date, results)

Hib 1._____ 2._____ 3._____ 4._____

Hepatitis A 1._____ 2._____

Hepatitis B 1._____ 2._____ 3._____

Chicken Pox (Varicella) Vaccine 1._____ 2._____ 3._____

Chicken Pox (Varicella) Disease Date _____

Pneumococcal Conjugate 1._____ 2._____ 3._____ 4._____

Meningococcal Conjugate _____

HPV (Human Papillomavirus) 1._____ 2._____ 3._____

Influenza _____

_____ MD Signature

_____ Date

Operations or accidents

Behavior (Please list any habits which may assist the Health Officer in meeting your child's needs)

Family History

	Year of Birth	State of Health
Father		
Mother		
Brother(s)		
Sister(s)		

Has any relation had any of the following:

Significant Allergy	Yes	No	Relation
Rheumatic Fever	Yes	No	Relation
Heart Disease	Yes	No	Relation
Diabetes	Yes	No	Relation
Tuberculosis	Yes	No	Relation
Convulsive Disorder	Yes	No	Relation
Mental Illness	Yes	No	Relation
Cancer	Yes	No	Relation