BERGENFIELD PUBLIC SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT
Roy W Brown Middle School / Bergenfield High School

STUDENT RECORD OF DISCLOSURE & RELEASE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses of their protected health information (PHI). The individuals also provided the right to request confidential communications or that a communication of PHI be made by the alternative means, such as correspondence to the Individual's office instead of the individual's home.

NAME OF CHILD: _____
Last name First Name

DATE OF BIRTH: _____

NAME OF TRANSFERRING SCHOOL: _____

ADDRESS: _____

GRADE COMPLETED: _____

I GRANT MY PERMISSION TO RELEASE MY CHILD'S HEALTH RECORDS TO THE FOLLOWING:

SCHOOL ADDRESS:

_____ Roy W Brown Middle School
130 South Washington Avenue
Bergenfield, NJ 07621
Attn: A.M. Murphy, RN, MA,CSN

_____ Bergenfield High School
80 South Prospect Avenue
Bergenfield, NJ 07621
Attn: Loretta Borrows, RN, BA, CSN

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to authorization requested by the Individual Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

DATE	DISCLOSED (To Whom/ Address/ Fax #)	DESCRIPTION (Of Disclosure/Purpose)	BY WHOM DISCLOSED	DATE RECEIVED

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 ☐ Male ☐ 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	LEAD SCREENING Result
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT, indicate in corner box)							
Tdap							
POLIO - INACTIVATED POLIO VACCINE (IPV) If oral vaccine, indicate (OPV) in corner box							
MEASLES, MUMPS, RUBELLA (MMR)							
HAEMOPHILUS B (HIB)**							
HEPATITIS B							
VARICELLA							
PNEUMOCOCCAL CONJUGATE **							
MENINGOCOCCAL							
HEPATITIS A ***							
HPV (HUMAN PAPILLOMAVIRUS) ***							
OTHER							

Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

☐ Provisional admission attached-Date Granted: _____ ☐ Medical exemption attached ☐ Religious exemption attached

HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR
ALLERGIES		DRUG ALLERGIES		NEUROMUSC. DISORDER		AUTISM SPECTRUM DISORDERS	
ASTHMA		HEART DISEASE		CHRONIC OTITIS MEDIA		HEMATOLOGICAL DISORDERS	
CONGENITAL DISORDER		HEPATITIS		AUTO IMMUNE DISORDERS		**OPERATIONS OR INJURIES**	
CONVULSIVE DISORDER		LYME DISEASE		STREP INFECTIONS			
DIABETES		MONONUCLEOSIS		JUVENILE RHEUMATOID ARTHRITIS			

****MANTOUX - Date Planted: _____ Date Read: _____ Results: _____**

****REQUIRED FOR DAY/CHILD CARE ENROLLEES (2 Months-5th Birthday Only) ***Not Required**

VA-16 AUG. 75 **FY-09**

NEW JERSEY STATE DEPARTMENT OF HEALTH
NOTICE TO PARENTS/GUARDIANS REGARDING IMMUNIZATION DEFICIENCIES

To the Parents/Guardians of _____

Your child's health record shows that immunization requirements for school attendance are incomplete. The boxes circled below indicate the immunization(s) that are missing.

If you have records which show that these immunizations have been received, please present them at your earliest convenience and have the information transcribed to the school's health record. The immunization regulations permit provisional or temporary attendance at school upon filing of a request for provisional admittance. If your child requires more than one doctor visit to complete these requirements, have your physician or local health officer complete the attached form. Failure to comply with the State's immunization requirements will prevent your child from attending school.

_____ _____ _____

Date **School Nurse** **Phone Number**

Check if you need either of these forms: Medical Contraindication _____ **Religious Exemption** _____

DO NOT DETACH
PROVISIONAL ADMITTANCE REQUEST

I request to have my child provisionally admitted to school pending the completion of the minimum immunization requirements. I affirm that the immunizations required will be completed as soon as possible and in accordance with the appointment schedule provided by our family physician or local health department.

Expiration of Provisional Admittance _____

_____ _____ _____

Date **School Nurse** **Phone Number**

The above pupil's immunization series has been initiated and he/she is in the process of complying with all the immunization requirements. I have arranged an appointment schedule and agree to provide the remaining immunizations. All immunization requirements should be met by _____

_____ _____ _____

Signature of Physician/Date **Name/Address Physician Clinic** **Phone Number**