

PATERSON PUBLIC SCHOOL PHYSICAL EXAMINATION FORM

DATE OF EXAM _____

PATERSON PUBLIC SCHOOL # _____

SCHOOL NURSE: 973-321- _____

DATE GIVEN _____

DUE BACK _____

TIME _____

DATE RETURNED _____

STUDENT NAME: _____

DOB: _____

AGE: _____

SEX: M F

GRADE: _____

ADDRESS: _____

PATERSON, N.J. _____

HISTORY OF ILLNESS OR ABNORMALITIES:

Vision (R) 20/ _____ (L) 20/ _____ Corrected Y / N _____ Glasses: Y / N _____ Contacts Y / N _____ Hearing (R) _____ (L) _____

Height _____ % Weight _____ % B/P _____ / _____ Pulse _____ bpm

Allergies _____

Asthma _____

Ears _____

Eyes _____

Lymph Glands _____

Thyroid _____

Nose _____

Throat _____

Teeth _____

Mouth _____

Heart _____

Murmur Yes No

Lungs _____

Abdomen _____

Hernia _____

Genito-Urinary _____

Orthopedic: Structural _____

Posture _____

Feet _____

Scoliosis _____

Skin _____

Nutrition _____

Nervous System _____

Speech _____

General Appearance _____

Other _____

What if any modifications are required for full participation in the school program? _____

What medical factors may effect his/her growth, development and/or academic progress? _____

Is the child receiving medication? _____

Other therapy? _____

If so, what are the side effects with regard to his/her academic progress in school? _____

Referrals made as a result of this examination: _____

PHYSICIAN'S SIGNATURE _____

TELEPHONE _____

ADDRESS _____

FAX _____

PRINT PHYSICIAN'S NAME _____

IMMUNIZATIONS:

DTP/ DTaP /Td

POLIO

MMR

HEP B

HIB

BCG

1. _____

1. _____

1. _____

1. _____

1. _____

1. _____

2. _____

2. _____

2. _____

2. _____

2. _____

OTHER

3. _____

3. _____

3. _____

3. _____

3. _____

4. _____

4. _____

4. _____

4. _____

4. _____

5. _____

5. _____

VZV

Varicella Disease Statement or Laboratory Evidence Attached

Tdap

MENINGOCOCCAL

1. _____

OTHER:

1. _____

1. _____

2. _____

PPD Mantoux Test: Planted _____ Read _____ Result _____ mm

CXR: Y / N Date: _____ Result: _____ INH: Y / N _____ mg. X _____ mos. Date started: _____ Date Completed _____

Blood Lead Level _____ mcg/dL Date Tested _____ Not Available _____ REFERRED TO FOR TESTING _____