**NORTH ARLINGTON PUBLIC SCHOOLS**

**NORTH ARLINGTON, NEW JERSEY**

REPORT OF PHYSICIAN EXAMINING CHILD

**REQUIRED FORM TO BE COMPLETED BY PHYSICIAN AND RETURNED TO SCHOOL**

(Student’s Name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Date of Birth) (Grade) (School Term)

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(Physician) (Phone) (Address)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE DOCUMENT IMMUNIZATIONS BELOW**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DPT** | **1** | **2** | **3** | **4** | **5** |
| **Tdap** |  |  |  |  |  |
| **Polio Vaccine** | **1** | **2** | **3** | **4** | **5** |
| **MMR (or lab evidence of disease)** | **1** | **2** |  |  |  |
| **HIB** | **1** | **2** | **3** | **4** |  |
| **Hepatitis B** | **1** | **2** | **3** |  |  |
| **Varicella** | **1** | **2** |  |  |  |
| **Prevnar** | **1** | **2** | **3** | **4** |  |
| **Hepatitis A** | **1** | **2** |  |  |  |
| **Meningococcal** |  |  |  |  |  |
| **HPV** |  |  |  |  |  |
| **Other** |  |  |  |  |  |
| **Tuberculin Test Type: PPD** | **Date:** | **Results:** |
|  **Chest Xray Date: Results:** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Normal** | **Abnormal** |  | **Normal** | **Abnormal** |
| **Appearance** |  |  | **Glands** |  |  |
| **Nutrition** |  |  | **Heart** |  |  |
| **Skin** |  |  | **Lungs** |  |  |
| **Head** |  |  | **Abdomen** |  |  |
| **Eyes** |  |  | **Reflexes** |  |  |
| **Ears** |  |  | **Spine** |  |  |
| **Nose** |  |  | **Feet** |  |  |
| **Throat** |  |  | **Neurological** |  |  |
| **Teeth** |  |  | **Speech** |  |  |
| ***Allergies*** |  | **Other** |  |  |
|  | ***Weight*** | ***Height*** |
|  |  |
| ***Blood Pressure*** | ***Vision*** | ***Hearing*** |
|  |  |  |

**COMMENTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does this student require any restrictions of physical education activities? (NO)\_\_\_\_\_\_\_\_ (YES)\_\_\_\_\_\_\_\_**

**If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STAMP (Physician’s Signature) (Date)**

**Revised form 2/23/21/co**