HOLMDEL TOWNSHIP PUBLIC SCHOOLS

Health Examination Form for New Students

Student's Name: _____

Address: _____

Date of Birth: _____ Age: _____

School: _____ Grade: _____

	Date	Date	Date	Date	Date
DTAP	_____	_____	_____	_____	_____
IPV/OPV	_____	_____	_____	_____	
Hepatitis A	_____	_____	_____		
Hepatitis B	_____	_____	_____		
Varivax	_____	_____	or disease date	_____	_____
MMR	_____	_____			
Measles	_____	Mumps	_____	Rubella	_____
Mantoux Test	Date given:_____		Date read: _____		Result (MM)_____

	Normal	Abnormal	Comments
Height _____	☐	☐	_____
Weight _____	☐	☐	_____
Eyes (i.e, Wears glasses?)	☐	☐	_____
Ears	☐	☐	_____
Respiratory	☐	☐	_____
Cardiovascular	☐	☐	_____
Blood Pressure _____	☐	☐	_____
Abdominal	☐	☐	_____
Musculo-Skeletal	☐	☐	_____
Skin	☐	☐	_____
Neurological	☐	☐	_____
Genitalia	☐	☐	_____

Other _____

_____

Presently taking medication? No ☐ Yes ☐

If yes, will this be taken during school? No ☐ Yes ☐

If yes, please provide a doctor's prescription/order to the school nurse as per attached form.

Restrict in Physical Education? No ☐ Yes ☐

Please explain _____

Examining Physician (type or print) _____

Physician's Signature _____ Date _____

Physician's Address _____ Telephone No. _____