PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837
HEALTH SERVICES

HEALTH CARE PROVIDER EXAMINATION (Grades Pre K-12 Excluding Sports))
RETURN TO THE SCHOOL NURSE

N.J.A.C. 6A:16-2.2 requires all medical examinations must be done by the student's family physician or clinic where the student receives his/her healthcare.
If you do not have a family physician or clinic who provides medical care for your child, please contact the school nurse for a school physician exam request form.

Student: ______________________________________ **Grade:** _____________ **School:** _____________ Male/Female (circle one)

Date of Birth: _______________

IMMUNIZATIONS ADMINISTERED ____

LABORATORY TESTS DONE ____

____ **T.B. Mantoux Test: (date)**_____________________**Result** _________**mm.**

RECORD OF PHYSICAL EXAMINATION:

Hearing R: __________ L _________

Height: ____________ Weight: _________ Blood Pressure: _________ Pulse: ___________ Vision R: __________ L _________

Vision correction (glasses/contacts):_____________________ Hearing/Ears (tubes/hearing aides): ___________________________

Skin and scalp:_______________________________ Abdomen: ____
Rashes _______ Jaundice ________Infection ________ Hepatomegaly ________ Splenomegaly _______ Mass _________________
Head and neck:____ Lymph nodes:____
Nose and throat:_____________________________________ Teeth:____
Extremities:____ Inguinal area (hernia):____
Mobility ____________________________ Deformity ______________________ Instability __________________________________
Lungs: ____ Other:____
Neurological: ______________ Reflexes ______________ Balance __________________ Coordination ________________________
Females: Normal Menstruation: ____________ Males: ___________ Hernia: ___________ Testes Descended
Heart (any irregularity? If yes, please explain): Murmurs __________________ Rhythm/Rate _________________________________
Injuries, operations? Explain: ____
Chronic Illness/Disease:
____
Orthopedic defects, e.g., scoliosis: Yes ____ No ____. Treatment necessary? ____
Mobility ______________________ Instability ________________________ Deformity ____
Medications being taken by the student? No ______ Yes __________ If yes, please list: ___________________________________

****

Assessment of Physiologic Maturation:
____

General condition of student:
____

Are there any health findings which might have an effect on the educational management of the student? If yes, please explain:
____

In your opinion, is the student capable of carrying a full program in physical education, and field trips?

Yes ____ No ____. Explain:
____

Restrictions of Activity Recommended:____

___________________________________ ________________________________ ______________________________
Name of Healthcare Provider (please print) Signature of Healthcare Provider Telephone Number

____ ____________________________
Address Date of Exam

Revised:12/03, 4/04
file:NHSM Form 16

(over)

PUBLIC SCHOOLS OF EDISON TOWNSHIP
EDISON, NEW JERSEY 08837

HEALTH HISTORY
(TO BE COMPLETED BY PARENT OR GUARDIAN)

Student's Name: ____________________________ Grade/Section: _________ School: ______________

1.	Has student ever been hospitalized or had surgery?	Y	N
1a.	Significant illness or injury in past year or less? (sprain, mononucleosis,etc.)	Y	N
2.	Is student presently taking any medication? (daily or occasionally)	Y	N
3.	Does student have any **severe allergies** to (medicines, foods, or insects)?	Y	N
3a.	Does student have an EpiPen for severe allergic reaction?	Y	N
4.	Has student ever passed out during or after exercise ?	Y	N
	Has student ever been dizzy during exercise?	Y	N
	Has student ever had chest pain during or after exercise?	Y	N
	Has student ever had high blood pressure?	Y	N
	Has student ever been told you had a heart murmur?	Y	N
	Has student ever had racing of your heart or skipped beats?	Y	N
	Has anyone in your family died of heart problems or sudden death before the age of 50?	Y	N
		Y	N
5.	Does student have any skin problems under treatment (itching, rashes, acne)?	Y	N
6.	Has student ever had a head injury or concussion?	Y	N
7.	Has student ever been dizzy or passed out in the heat?	Y	N
8.	Does student have any problems with hearing loss?	Y	N
9.	Does student have trouble breathing during or after exercise?	Y	N
9a.	Does student have asthma?	Y	N
9b.	Does student use asthma inhaler(s)?	Y	N
10.	Has student had any problems with eyes or vision?	Y	N
10a.	Does student wear contact lenses or glasses during sports?	Y	N
11.	Does student have any medical conditions (diabetes, seizure disorder, severe headaches, etc.)	Y	N
12.	Has student ever fractured or dislocated any of the following? Skull Neck Shoulder Arm Elbow Wrist Hand Thigh Leg Knee Ankle Foot	Y	N
13.	Does student wear orthodontic braces or retainer?	Y	N

14. Explain any YES answers (include dates): ____

____

____

____

____

Signature of Parent/Guardian: __________________________ DATE: ___________________