BRIDGEWATER-RARITAN REGIONAL SCHOOL DISTRICT
1st-12th GRADE – STUDENT HEALTH HISTORY

Date of last physical exam: _____

Student's Name _____ Date of Birth: _____ Age: _____ Sex: _____

School: _____ Grade: _____ Homeroom: _____

Address: _____ _____ Home Phone: _____
(Street) (City, State Zip)

Physician: _____ Phone: _____ Fax: _____

PAST MEDICAL HISTORY: Parent/Guardian to Complete, and Physician/Medical Provider to Review.

☐ Allergic Rhinitis	☐ Chicken Pox	☐ Earache	☐ Hypertension	☐ Rheumatic Fever
☐ Anemia	☐ Colds (Freq.)	☐ Fainting	☐ Kidney Stones	☐ Seizures
☐ Anxiety	☐ Colitis	☐ Gallstones	☐ Migraines	☐ Thyroid Disease
☐ Asthma	☐ Depression	☐ Hepatitis	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Diabetes	☐ Hiatal Hernia	☐ Pancreatitis	☐ _____

Other/Explain: _____

_____

_____

Known allergies: _____

_____

Medications Currently in Use: _____

_____

PAST SURGICAL HISTORY: ☐ Tonsillectomy ☐ Appendectomy ☐ Cholecystectomy

☐ Herniorrhaphy ☐ Other _____

_____

_____

Parent gives permission for the school nurse to share medical information with school staff as necessary.

_____ _____
Signature of Parent/Guardian Date

PHYSICIAN EVALUATION FORM

Student's Name: _____ D.O.B.___ _____ Grade: _____ Homeroom: _____

FOLLOWING INFORMATION TO BE COMPLETED BY PHYSICIAN OR MEDICAL PROVIDER

IMMUNIZATIONS: PLEASE ATTACH COPY OF CURRENT IMMUNIZATIONS.

Height: _____Weight: _____ Blood Pressure: _____ / _____ Pulse: _____ bpm _____

Vision: R 20/ _____L 20/ _____ Corrected: Yes / No Contacts: Yes / No Glasses: Yes /No

Pupils: Equal _____ Unequal _____ Hearing: R_____ L _____

Indicators	Normal		Abnormal Findings	Initials
Head/Neck	☐ Yes	☐ No		
Eyes / Sclera /Pupils	☐ Yes	☐ No		
Ears	☐ Yes	☐ No		
Nose / Mouth / Throat	☐ Yes	☐ No		
Heart: Murmur / Rhythm	☐ Yes	☐ No		
Lungs: Auscultation/Percussion	☐ Yes	☐ No		
Chest Contour	☐ Yes	☐ No		
Skin	☐ Yes	☐ No		
Abdomen: Assessment (include liver, spleen)	☐ Yes	☐ No		
Tanner Stage: Testes/Onset of Menses	☐ Yes	☐ No		
Hernia	☐ Yes	☐ No		
Neck/Back/Spine: Range of Motion	☐ Yes	☐ No		
Scoliosis	☐ Yes	☐ No		
Upper Extremities	☐ Yes	☐ No		
Lower Extremities	☐ Yes	☐ No		
Neurological: Balance & Coordination Romberg	☐ Yes ☐ Yes	☐ No ☐ No		
Heel Walk	☐ Yes	☐ No		
Tandem Walk	☐ Yes	☐ No		
Toe Walk	☐ Yes	☐ No		
Nose Touch	☐ Yes	☐ No		
Additional observations: _____				

CLEARANCE: A. Student may participate in Physical Education: ☐ Yes ☐ No

B. ***NOT CLEARED*** for Physical Education:

Diagnosis:_____

_____

Recommendations:_____

Provider's Signature:_____

Date of Exam: _____

Physician/Provider Stamp