

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, NJ _____

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 affect 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 _____

NJIS Registry No. _____

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.				

VARICELLA DISEASE STATEMENT OR LABORATORY EVIDENCE ATTACHED: YES / NO

Tdap	MENINGOCOCCAL	VZV	OTHER
1.	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 _____

FR-7 _____ YES _____ NO ASTHMA TREATMENT PLAN SENT _____ YES _____ NO ASTHMA TREATMENT PLAN RETURNED _____

08/18ec