



The Rumson Country Day School
Physicians Report
Student Health History – Grades N-4th

Student's Name _____ Date of Birth _____

School _____ Age _____ Grade _____

Significant or Past Illness or Injury _____

Varicella Disease _____

Allergies _____

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	LEAD SCREENING	
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination <i>*(If Td or DT, Indicate in corner box)</i>						Test Date	Result
Tdap							
POLIO – INACTIVATED POLIO VACCINE (IPV) <i>If oral vaccine, indicate (OPV) in corner box</i>							
MEASLES, MUMPS, RUBELLA (MMR)						Document below single antigen vaccine receipt, serology titers, or varicella disease history	
HAEMOPHILUS B (HIB)**							
HEPATITIS B						Hepatitis B	Date: _____ Titer: _____
VARICELLA						Varicella	Date: _____ Titer: _____
PNEUMOCOCCAL CONJUGATE **						Measles	Date: _____ Titer: _____
MENINGOCOCCAL						Mumps	Date: _____ Titer: _____
HEPATITIS A ***						Rubella	Date: _____ Titer: _____
HPV (HUMAN PAPILLOMAVIRUS) ***							
OTHER							

Examination: _____

Height _____ Weight _____ BP _____

Vision Tested? Yes _____ No _____ Vision R 20/____ L 20/____ Wears Glasses? _____

Hearing Tested? Yes _____ No _____ Hearing R _____ L _____

Respiratory _____ Cardiovascular _____

Liver _____ Spleen _____ Hernia _____

Musculo-Skeletal _____ Skin _____

Scoliosis Screening _____ Genitalia _____

Neurological _____ Urinalysis performed? Yes _____ No _____

Presently taking medication? Yes _____ No _____ If yes, will this be taken during school? _____

If yes, please specify: _____

Restrictions in Physical Education? Yes _____ No _____ Comments _____

Mantoux TB Test Given? Yes _____ No _____ Date _____ Results _____

Signature of Examining Physician _____ Date _____

Physicians Address _____ Phone _____