PARK RIDGE PUBLIC SCHOOLS
85 Pascack Road
Park Ridge, NJ 07656
Phone: 201-573-6000

New Student Registration
Student Medical Examination
(to be completed by a licensed health provider)

Student Name: ______________________ Date of Birth: __________ ☐ Female ☐ Male

Home Address: ____

School: ______________________ Grade: ______________

Immunization History:

DTaP: 1. ________ mm/dd/yy 2. ________ mm/dd/yy 3. ________ mm/dd/yy 4. ________ mm/dd/yy 5. ________ mm/dd/yy ________ *Booster*

Tdap:
(for students born after January 1997 and students entering Grade 6) ________ *Booster*

Polio

IPV: 1. ________ mm/dd/yy 2. ________ mm/dd/yy 3. ________ mm/dd/yy 4. ________ mm/dd/yy 5. ________ mm/dd/yy

OPV: 1. ________ mm/dd/yy 2. ________ mm/dd/yy 3. ________ mm/dd/yy 4. ________ mm/dd/yy 5. ________ mm/dd/yy

MMR: 1. ________ mm/dd/yy 2. ________ mm/dd/yy 3. ________ mm/dd/yy

Measles: 1. ________ mm/dd/yy 2. ________ mm/dd/yy

Mumps: 1. ________ mm/dd/yy 2. ________ mm/dd/yy **Varicella Zoster:** 1. ________ mm/dd/yy 2. ________ mm/dd/yy

Rubella: 1. ________ mm/dd/yy 2. ________ mm/dd/yy

HIB Vaccine: 1. ________ mm/dd/yy 2. ________ mm/dd/yy 3. ________ mm/dd/yy 4. ________ mm/dd/yy 5. ________ mm/dd/yy

Hepatitis A Vaccine: 1. ________ mm/dd/yy 2. ________ mm/dd/yy

Hepatitis B Vaccine: 1. ________ mm/dd/yy 2. ________ mm/dd/yy 3. ________ mm/dd/yy

PPD Mantoux: Date Tested: ________ Date Read: ________ Results: ________

Lead Test: Date Tested: ________ Lead Level: ________

Influenza Vaccine:
(mandatory for pre-school students) 1. ________ mm/dd/yy 2. ________ mm/dd/yy 3. ________ mm/dd/yy 4. ________ mm/dd/yy

Pneumonoccal Vaccine:
(mandatory for pre-school students) 1. ________ mm/dd/yy

Meningococcal Vaccine:
(mandatory for incoming Grade 6 students) 1. ________ mm/dd/yy 2. ________ mm/dd/yy 3. ________ mm/dd/yy

Other (specify): ____

PARK RIDGE PUBLIC SCHOOLS
85 Pascack Road
Park Ridge, NJ 07656
Phone: 201-573-6000

New Student Registration
Student Medical Examination
(to be completed by a licensed health provider)

Student Name: ______________________ Date of Birth: __________ ☐ Female ☐ Male

Home Address: ____

School: ______________________ Grade: ______________

Growth and Development: Normal ________ Premature ________ Term ________

Complications ______________________________________

Early illness or injury ______________________________________

Systems Review:

Height ________ Weight ________ BMI ________ Blood Pressure ________

Vision: R ______ L ______ B ______ Glasses/Contacts ______________

Audio: R ______ L ______ ENT ______________ Speech ______________

Integument	________	Head & Neck	________	Lymphatic	________
Respiratory	________	Cardiovascular	________	Abdomen	________
Gastrointestinal	________	Genitourinary	________	Urinalysis	________
Musculoskeletal	________	Hernia	________	Scoliosis	________
Nervous	________	Emotional Symptoms	________	Nutrition	________

Neurological/Psychological: ______________________________________

General Assessment: ______________________________________

Remarks (Please list any special needs and/or medication required.): ______________________

____

____

Medical History:

	Year		Year		Year		Year
Allergies		Asthma		Ottis Media		Operations/Injuries	
Drug Sensitivities		Chicken Pox		Rheumatic Fever			
Lyme Disease		Seizure Disorder		Strep Infections		Hospitalizations	
Hepatitis		Diabetes		Mononucleosis			
Neuromuscular Disease		Heart Disease		Other		Congenital Defects	

Date of Examination: ______________ Physician's Signature: ______________________

______________________ ______________________ ______________

Physician's Name *(please print)* Office Address Office Phone