ANNA L. KLEIN SCHOOL

301 69th Street
Guttenberg, NJ 07093
Tel: 201.861.3100 (x16)
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Michelle Rosenberg
Superintendent

Keith Petry
Principal

Name: _____ Birth Date_____

THIS FORM MUST BE COMPLETED BY THE PHYSICIAN AND RETURNED TO THE SCHOOL NURSE WITHIN _____DAYS

Physician please attach a copy of the most recent immunization record*

Height:	**Ears:**	**Dermatitis:**
Weight: **BMI:**	**Hearing loss:** **Rt. _____ Lt. _____**	**Nutrition:**
Blood Pressure:	**Head / Neck:** **Tonsils:**	**Lungs:**
Pulse:	**Glands:**	**Allergies:**
Eye/Sclera/Pupils:	**Teeth:**	**Anaphylaxis:**
Vision without glasses: **Rt. _____ Lt. _____**	**Gums:**	**Speech:**
Vision correction with Glasses/Contacts: **Rt. _____ Lt. _____**	**Nose:**	**Genitalia:**
Glands: (specify)	**Seizures:**	**Abdomen:**
Stomach:	**Hernia:**	**Orthopedic:**
Scoliosis:	**Structural:**	**Feet:**
Asthma/RAD(circle which one): ***Yes* _____ *No* _____** **Medication:** **Inhaler: _____** **Nebulizer:_____** **Dosage: _____** **Frequency:_____** **No Medication: _____**	***Heart Rhythm:* _____** ***Murmur:* *Yes* ____ *No* ____** **Is this child under the care of a** **Pediatric Cardiologist?** **Yes _____ No _____** **Diagnosis:**	**Developmental Assessment:** **_____** **Fine/Gross Motor: _____** **_____** **Language Development:** **_____** **Autism Spectrum:** **Yes _____ No _____** **Down's Syndrome:** **Yes _____ No _____**

Mantoux**	**Date Given:**	**Date Read:**	**Results (MM)**	**Chest X-ray Result:**	**Medication:** **Date Started:** **Date Completed:**

****Mantoux Test is required for students entering U.S. School for the first time in New Jersey or transfering into a NJ school from any country not listed on the Exemption list.**

(Must be completed by the Medical Doctor)

General Student Condition:

Does this patient take any medication? Yes ___ No ___

Please indicate name of the medication:
_____

Is there a history of any serious injuries, accidents or operations? Yes ___ No ___

Is there any impairment, disease or illness, past or present, of which the school should be informed, and to which special consideration should be given? Yes ___ No ___

Please indicate any significant findings that the school should notified: _____

Is the child under the care of a specialist? Yes ___ No ___

If yes, who and why? _____

Physical Education:

- Full activity recommended:_____
- No competitive or contact sports:_____
- Limited activity prescribed as follows:_____
- Exclusion because:_____
- Restricted (dates) from:_____ to:_____

Date of Physical Exam: _____

Vaccine Type	1st Dose Mo/Day/YR	2nd Dose Mo/Day/YR	3rd Dose Mo/Day/YR	4th Dose Mo/Day/ YR	5th Dose Date Mo/Day/YR	Lead Screenings	
DIPHTHERIA, TETANUS, PERTUSSIS (DTAP)							
Td							
POLIO – (IPV)							
MEASLE, MUMPS, RUBELLA (MMR)							
HAEMOPHILUS B (HIB)							
HEPATITIS B							
VARICELLA					Document below single antigen vaccine receipt, serology titers or varicella disease history		
PNEUMOCOCCAL CONJUGATE**							
HEPATITIS A***					HEPATITIS B	DATE:	TITER:
MCV4							
PHYSICAL EXAM					VARICELLA	DATE:	TITER:
Individual Health Plan	Asthma/RAD	Seizure/Cardiac	Cancer/Medical	Food Allergy	RUBELLA	DATE:	TITER:

****Physician please attach a copy of the most recent immunization record or complete the above immunization documentation*****

Physician's Signature	Physician's Name (Print)	Date	Health Care Providers Stamp