ANNA L. KLEIN SCHOOL

Dr. Michelle Rosenberg
Superintendent

Keith Petry
Principal

Name: _____ Birth Date_____ Sex: _____ Gender: _____

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: _____

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

(Must be completed by the Medical Doctor)