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, N.J.________

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 effect 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____________________

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.______				

VZV

Varicella Disease Statement or Laboratory Evidence Attached ☐

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__________

☐ YES ☐ NO ASTHMA TREATMENT PLAN SENT ☐ YES ☐ NO ASTHMA TREATMENT PLAN RETURNED