NORTH PLAINFIELD PUBLIC SCHOOLS
MEDICAL FORM TO BE COMPLETED BY THE PHYSICIAN

NAME OF CHILD_____DATE OF BIRTH_____

PARENTS NAME _____ADDRESS_____

Past Medical History:
*Chicken Pox*_____ *Measles*_____ *German Measles*_____ *Mumps*_____
*Allergies*_____ *Asthma*_____ *Strep Infection*_____ *Speech Defect*_____
*Scarlet Fever*_____ *Tonsillitis*_____ *Otitis Media*_____ *Hepatitis*_____
*Premature Delivery*_____ *Normal Delivery*_____
*Operations*_____

Neurological Exam: *Coordination: Good*_____*Fair*_____*Motor Ability: Good*_____*Fair*_____
*Hyperactivity*_____

*DATE OF EXAM:*_____

Physical Examination: *Height* _____ *Weight* _____ *B.P.*_____

*Eyes*_____ *Skin*_____ *Genitalia*_____ *Scoliosis*_____ *Spine* _____

*Ears*_____ *Scalp*_____ *Urinalysis*_____ *Lymph Nodes*_____ *Throat*_____

Heart _____*Nutrition*_____ *Congenital Condition*_____

Immunizations:

*DPT(1)*_____ *Polio (1)*_____ *MMR (1)*_____ *HIB (1)*_____ *Hep B (1)*_____

*(2)*_____ *(2)*_____ *(2)*_____ *(2)*_____ *(2)* _____

*(3)*_____ *(3)*_____ *Measles*_____ *(3)*_____ *(3)* _____

*(4)*_____ *(4)*_____ *Mumps*_____ *(4)*_____ *Varivax (1)*_____

*(5)*_____ *(5)*_____ *Rubella*_____ *Flu*_____ *(2)*_____

Tdap _____ *Prevnar (1)*_____ *(2)*_____ *(3)*_____ *(4)*_____ *Meningitis*_____

*Hep A (1)*_____ *(2)*_____ *Other* _____

*Last Lead Level*_____ *Date:*_____

Mantoux Test *Date:*_____*Results: Negative*_____ *Positive*_____*mm*

*IF POSITIVE: Chest X-Ray: Date*_____*Results*_____
*Medication prescribed? Yes*_____*No*_____

*Visual Acuity:20/*_____*20/*_____*Is child under care of ophthalmologist? Yes*_____ *No*_____
*Was Audiometric Screening done?*_____ *Results*_____

*Any physical handicaps-should activities be restricted?*_____
*State reason and duration*_____

Is child receiving any medication for:
*(1)Allergies*_____*(2)Behavior Modification*_____*(3)Other* _____

Date _____Signature of Physician_____M.D.

_____ _____
Stamped Name/Address Phone No.

Rev. 1/2015