BOROUGH OF FREEHOLD PUBLIC SCHOOLS
FREEHOLD, NEW JERSEY

Student Physical Examination
(To be completed by Physician)

STUDENT: _____ DATE OF EXAMINATION: _____
ADDRESS: _____ DATE OF ENTRY: _____
DATE OF BIRTH: _____ SEX: _____ HEIGHT: _____ WEIGHT: _____
VISION: _____ HEARING: _____ BLOOD PRESSURE: _____

DISEASE HISTORY: (Please specify type and age at onset)

Allergies _____ Convulsive Disorder _____
Congenital Defects _____ Diabetes _____
Drug Sensitivities _____ Heart Disease _____
Hepatitis _____ Otitis Media _____
Neuromuscular Disorder _____ Rheumatic Fever _____
Asthma _____ Strep Infections _____
Chicken Pox _____ Mononucleosis _____
Other Illnesses _____
Operations or Injuries _____

CURRENT MEDICAL PROBLEMS & TREATMENTS:

PHYSICAL EXAMINATION: (Please note every item)

Ears (Otoscopic) _____ Genito-Urinary _____
Eyes _____ Orthopedic:
Lymph Glands _____ Structural _____
Thyroid _____ Extremities (Head & Neck) _____
Nose _____ Posture _____
Throat _____ Feet _____
Teeth/Mouth _____ Skin _____
Heart _____ Nutrition _____
Lungs _____ Nervous System _____
Abdomen _____ Reflexes _____
Hernia _____ Speech _____
General Appearance _____ Other _____

BLOOD TEST FOR PRESCHOOL ONLY: **Lead** _____ **Sickle Cell** _____

IMMUNIZATION RECORD: (Please give full dates--month/day/year)

DPT (1)_____ (2)_____ (3)_____ (4)_____ (5)_____
(Total 4 - If the 4th is prior to the 4th birthday, needs 1 after 4th birthday - No more than 5 dosages.)

OPV (1)_____ (2)_____ (3)_____ (4)_____
(Total 3 - If the 3rd is prior to the 4th birthday, needs one after 4th birthday.)

MMR (1)_____ (2)_____ (Measles, Mumps, Rubella Vaccine)
(Given after 1st birthday, 2nd separated by at least 1 month)

HIB (1)_____ (2)_____ (3)_____
(1 to 3 vaccines - PreSchool Requirement)

Hepatitis B: (1)_____ (2)_____ (3)_____ (three dose requirement)

Chicken Pox (Varicella/Varivax) (1)_____ **Mantoux Test:** (1)_____/Results_____ (If out of State or Country)

Influenza Vaccine (1)_____ **Pneumococcal Conjugate Vaccine (PVC)** (1)_____

Meningococcal Vaccine (1)_____

Is this child under treatment_____ or medication _____ Is medication needed in school? _____

RECOMMENDATIONS OR RESTRICTIONS (IF ANY): _____

I have examined this child and find him/her physically fit to participate in all school activities (including sports).

_____ _____
(Physician's Phone Number) (Signature of Physician)

Physician's Name (Please print): _____