**1295 Inman Ave**
**Edison, NJ 08820**
**908-754-1882, Ext. 130**
**School Nurse**

## Annual Medical Examination Form
## Required for ALL students PreK-Grade 12 annually every 365 days

If your child is in grades 6-12 and intends to participate in a sport, there are **ADDITIONAL** different forms **also REQUIRED.** Please check our school website for additional student-athlete forms and requirements, or contact the school nurse and/or our athletic trainers.

Student Name: _____

Date of Birth: _____ Grade: _____ Male _____ Female _____

### Part 1: Parent Questionnaire

Has your child had any of the following? Please check the appropriate box.
If yes, please give dates/ details on line provided.

| Condition/Concern | Yes | No | Details |
|---|---|---|---|
| Concerns with kidney / Urinary | | | |
| Asthma/Inhaler / breathing trouble / pain with breathing | | | |
| Headaches / Migraines (specify treatment) | | | |
| Diabetes / Metabolic Disorder (specify disease) | | | |
| Joint problems / fractures / dislocation (specify) | | | |
| Neurological (i.e. ADD) / Seizures (specify) | | | |
| Orthopedic / spinal concerns / back / neck | | | |
| Heart Cardiac Problems - Specify (i.e. palpitations, pain) | | | |
| Head injury / concussion / loss of consciousness | | | |
| Fainting / Fainting related to exercise / exercise related problems | | | |
| Vision problems - glasses / contacts (specify) | | | |

Student Name: _____

| Hearing difficulties / ear infections | | | |
|---|---|---|---|
| **Condition/Concern** | **Yes** | **No** | **Details** |
| Experiencing fatigue / tiredness | | | |
| Any Surgery / surgeries | | | |
| Psychiatric diagnosis / emotional problems/ stress / anxiety | | | |
| Any Allergies | | | |
| Does your child carry or have an Epi pen? | | | |

Any other concerns not listed above: Yes or No (please circle) _____

Is your child under medical care now? If yes, please comment below.

_____

Has your child been told by a medical professional not to participate in sports/gym/school/camp? Yes or No (please circle)

Is there a history of sudden death in the family? Yes or No (please circle)

***Parent Consent:*** *I authorize Wardlaw-Hartridge School personnel, administrators, nurse(s), ch.226 nurse/s , 3rd party hired nurses/subs, to share confidential medical information on a need to know basis, with appropriate Wardlaw-Hartridge employees (and affiliated agencies, like food services). I understand that sharing of medical information is to help promote the health and safety of my child. I authorize the school nurse(s), and employees of Wardlaw-Hartridge School to perform first aid, screenings, illness and emergency care for my child, as deemed necessary. Parent authorizes the school nurse to contact MD if needed. A parent can refuse non-emergency nurse screenings by stating so in writing to the nurse. All medications given/taken during school hours require a written doctor's order and written parental consent in order for the nurse to administer or for the student to self-administer. See school nurse for forms. Parent/s and Guardian/s are advised to keep school nurses current with updates on medical issues or changes.*

**Parent/Guardian Signature:** _____ **Date:** _____

**Student Signature (18 & over):** _____ **Date:** _____

**Part 2:**
**Immunization: Special note for students in grades** *PreK, JK, K, 1st, 6th, and any new students, an updated immunization record must be attached.*

Student Name: _____

**Part 3:**
**Medical Examination** by private /primary MD, DO, APN.
This section is to be completed and signed by an examining health professional, not parent/guardian.

Date of Examination: _____HR:_____RR:_____***BP:**_____
***Height:**_____***Weight:** _____ *****BMI:_____ Percentage:_____
***Hearing right** _____ ***Hearing left**_____ **(*required by MD)**
***Vision right**_____ ***Vision left** _____ corrected, Yes or No (please circle)
***Scoliosis:** Yes or No (please circle) (*all required by MD at time of exam annually)
Explain: _____

Allergies: Yes or No (please circle) if yes please list: _____
Epi-pen: Yes or No (please circle)

Medical Conditions / Chronic Illnesses:

_____

Surgical History or injuries:

_____

General or exercise related conditions:

_____

Medications prescribed/taken:

_____

| Examination of:<br>Please comment if any conditions exist. | Normal<br>(check) | Abnormal-please note<br>Or use space for Comments |
|---|---|---|
| Vision: Eyes, Sclera,<br>(circle if ) Contact lenses, glasses, or both | | |
| Ears: Otoscopic, Hearing, Eardrum<br>If infections – perforation or hearing loss | | |
| Skin: Infections, scars, traumas, jaundice, or purpura | | |
| Head: Nose, Mouth, Teeth, list conditions of the head | | |
| Neck: Thyroid, Throat, Mobility | | |
| Cardiac: Rate & Rhythm, Murmurs (absent or present)<br>Heart related conditions | | |
| Pulmonary: Lung sounds, Chest Contour, Percussion | | |
| GU Kidney:<br>If male testes: normal or abnormal | | |
| Orthopedic: Skeletal, Spine, Joints, ROM,<br>any orthopedic conditions | | |
| Musculature: Coordination, Extremities, Strength | | |

Student Name: _____

| | | |
|---|---|---|
| Neurological: Balance, Gait, Cranial Nerves | | |
| Condition of Extremities: | | |
| Physiological Maturation: | | |

I, _____ (please print health professional's name), have

reviewed the parent questionnaire, reviewed this student's health history and performed a

thorough physical exam. It is my professional judgment that this student
(Check one)

_____ can participate fully,
_____ is not allowed to participate, or
_____ is limited in activity

in all aspects of school/sports/gym/camp, including full contact sports.

If limited please specify: _____ .

Please specify if student requires clearance by a specialist:

_____ .

Examining Health Professional's Signature:

_____ Date_____

Provider's Stamp:
(include name, address and phone number)

**Office Stamp:**