DEPARTMENT OF STUDENT SERVICES AND PROGRAMS
OFFICE OF SCHOOL HEALTH SERVICES

PERIODIC MEDICAL EXAMINATION NOTIFICATION

TO: The Parent/Guardian

FROM: The School Nurse

RE: _____ _____
Student's Name **School/Grade**

_____ _____
Birth Date (Mo/Day/Yr) **School Address**

DATE: _____

All kindergarten students and new entrants to the Hamilton Township Schools are required to have a medical examination. Parents/Guardians of students in grades 4, 7, and 10 are notified of the importance of regular medical examinations. Students should have the examinations performed privately by a physician of your choice because the pediatrician or family physician (medical home) is familiar with the student.

When you obtain a private examination, please have the form on the reverse side/or attached completed and returned. The required examination incorporates a review and examination of all body systems.

If your child participates in high school sports, you will need different physical forms completed by the doctor at the time of the examination. You can download these forms at www.hamilton.k12.nj.us. Click on **Curriculum Department** on the left side, and then click on **Athletic Forms** at the bottom of the page. Any questions, call the school nurse.

PLEASE ATTACH IMMUNIZATION RECORD TO PHYSICAL FORM

Thank you for your cooperation.

Per N.J.S.A. 18A:40-4
N.J.S.A. 6A:16-2.2

Rev. 08/16

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	