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 affect 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 _____

NJIIS Registry No. _____

IMMUNIZATIONS:

DTP/ DTaP /Td	**POLIO**	**MMR**	**HEP B**	**HIB**	**BCG**
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		OTHER
1	1.	2	

PPD Mantoux Test: Planted _____ Read _____ Result _____ mm

CXR: Y / N Date: _____ Result: _____ INH: Y / N _____ mg. _____ mos. Date started: _____ Date Completed _____

Blood Lead Level _____ mcg/dL Date Tested _____ Not Available _____ REFERRED TO FOR TESTING _____

a-7
13/12ec

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