LYNDHURST PUBLIC SCHOOLS
LYNDHURST , NEW JERSEY

Student Medical Examination/Immunization Record

REQUIRED FORM TO BE COMPLETED BY A LICENSED HEALTH PROVIDER

(Student's Name) **Sex**: M [ ] F [ ]

(Date of Birth) **(Grade)** **(School Term)**

PLEASE DOCUMENT IMMUNIZATIONS BELOW

DPT	**#1**	**#2**	**#3**	**#4**	**#5**
Tdap					
Polio Vaccine	**#1**	**#2**	**#3**	**#4**	**#5**
MMR	**#1**	**#2**			
HIB	**#1**	**#2**	**#3**	**#4**	
Hepatitis B	**#1**	**#2**	**#3**		
Varicella	**#1**	**#2**			
Prevnar	**#1**	**#2**	**#3**	**#4**	
Hepatitis A	**#1**	**#2**			
Meningococcal (after 11th birthday)					
HPV					
Other					
Tuberculin Test Type: PPD	**Date:**		**Results:**		

Systems Review:

	Normal	Abnormal		Normal	Abnormal
Appearance			**Glands**		
Nutrition			**Heart**		
Skin			**Lungs**		
Head			**Abdomen**		
Eyes			**Reflexes**		
Ears			**Spine**		
Nose			**Feet**		
Throat			**Neurological**		
Teeth			**Speech**		
Allergies			**Other**		

Height: _____ **Weight: _____** **Blood Pressure: _____**
Vision: R: _____ L: _____ B: _____ **Glasses [ ] Contacts [ ]**
Hearing: R: _____ L:_____

Please list any medical history and/or medication required.

_____

Student may participate in athletics/physical education: (NO)_____ (YES)_____
If NO, specify: _____
Duration: _____

_____ _____ **Physician STAMP**
(Physician's Signature) **(Exam Date)**

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(Physician-please print) **(Phone)** **(Address)**

Revised form 4/13/25