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 effect 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._____	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**	1._____	**OTHER:** _____		
1_____	1._____	2._____	_____		

PPD Mantoux Test: Planted_____ Read_____ Result_____ mm

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

Blood Lead Level_____ mcg/dL Date Tested_____ Not Available_____ REFERRED TO FOR TESTING_____

FR-7
08/18*ec*

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