



1295 Inman Ave
Edison, NJ 08820
908-754-1882, Ext. 130
School Nurse
Email to thuertas@WHSchool.org

Annual Medical Examination Form (AME)
Required for ALL students PreK-Grade 12 annually every 365 days
(regardless of sports participation)

If your child is in grades 6-12 and intends to participate in a sport, there is one **additional** form utilized. For athletes in grades 6-12 The Preparticipation Physical Medical Eligibility Form (MEF) is required. Please consult with our Athletics Department for the MEF. The MEF must be done by a NJ HCP authorized to perform cardiac assessment on an athlete. The MEF is the last page of the Preparticipation Physical Evaluation (PPE) required for athletes per NJ law. The PPE is required to STAY with the NJ doctor/HCP who performs the sports PPE. However, **only the one page MEF is required at school to participate in sports.** Contact the school nurse for questions on the AME. Contact the Athletics Department for questions on the MEF of the sports PPE.

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

Student Name: _____

Vision problems - glasses / contacts (specify)			
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: Please comment if any conditions exist.	Normal (check)	Abnormal-please note Or use space for Comments
Vision: Eyes, Sclera, (circle if) Contact lenses, glasses, or both		
Ears: Ooscopic, Hearing, Eardrum 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) Heart related conditions Pulmonary: Lung sounds, Chest Contour, Percussion GU Kidney: If male testes: normal or abnormal		
Orthopedic: Skeletal, Spine, Joints, ROM, any orthopedic conditions		

Student Name: _____

Musculature: Coordination, Extremities, Strength		
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:

