MONROE TOWNSHIP SCHOOL DISTRICT
PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION
(TO BE RETURNED TO THE SCHOOL)

IMMUNIZATION REGISTRY NUMBER	

NAME OF CHILD (Last, First, M.I.)	DATE OF BIRTH (Mo/Day/Yr)	SEX ☐ Male ☐ Female

PARENT OR GUARDIAN	NAME	TELEPHONE NO.
	ADDRESS	

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT, indicate in corner box)					
Tdap					
POLIO – INACTIVATED POLIO VACCINE (IPV) If oral vaccine, indicate (OPV) in corner box					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB)**					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE**					
MENINGOCOCCAL					
HEPATITIS A***					
HPV (HUMAN PAPILLOMAVIRUS)***					
OTHER					

LEAD SCREENING	
Test Date	Result

Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

☐ Provisional admission attached-Date Granted: _____ ☐ Medical exemption attached ☐ Religious exemption attached

	DATE GIVEN:	DATE READ:	RESULTS:
TB TESTING:			

Note: The Mantoux test is the ONLY accepted method of testing according to N.J. AC 6.29-4.2

Has child been tested for lead poisoning: Yes / No If Yes, Give Date _____ What are the results? _____

Medical History: (Give significant details, including serious illness, allergies, operations, accidents, etc.)

_____

Report of Examination: Ht. _____ Wt. _____ B/P _____ Visual Acuity _____

	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
EYES			HEART			POSTURE		
EARS			LUNGS			ORTHOPEDIC		
SKIN			ABDOMEN			REFLECTION		
NOSE & THROAT			SPINE			VISION		
TEETH			FEET			HEARING		
						HERNIA		

Explain abnormalities found _____

Is the child under treatment for any illness or abnormalities? YES _____ NO _____
If YES explain _____
Is the child taking any medication? YES _____ NO _____
May the Child participate in physical education activities and regular play? YES _____ NO _____
If NO, please specify restrictions _____

Signature of Physician	Address	Telephone	Date of Examination

Print Name of Physician _____