PARSIPPANY-TROY HILLS TOWNSHIP SCHOOLS

HEALTH SERVICES

PHYSICAL EXAMINATION FORM – *PRE-K – GRADE 5*

Name of Student:_____ **Date of Birth:**_____
Sex: M F (circle one) Age:____ **Grade:**____ **School:**_____
Address:_____ **City, State, Zip:**_____
Home Phone:_____

Health History

(to be completed by the parent)

Has your child had or do they currently have:

a. Any injury, illness, hospitalization or ER visits since their last exam? Y/N
If so, please list:_____
b. Any allergies to foods, bee stings, latex, pollen? Y/N/Don't know
If so, to what?_____
Please describe reaction:_____
c. Does your child currently take any medication prescribed by a doctor or over the counter medication on a daily basis? Y/N
If so, please list:_____
_____
d. Does your child take any medication on an as needed basis?
(i.e. Epipen, Albuterol inhaler, etc.). Y/N
Please list:_____

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.
Parent/Guardian Signature:_____ Date:_____

To be Completed by MD Office

Vaccine Type	Disease MM/DD/YR	1st Dose MM/DD/YR	2nd Dose MM/DD/YR	3rd Dose MM/DD/YR	4th Dose MM/DD/YR	5th Dose MM/DD/YR	Booster MM/DD/YR
DPT/DtaP/TdaP (Indicate type)	/ /						
IPV (indicate if OPV)	/ /						
MMR (indicate if separate vaccine)	/ /					**Measles Serology**	**Titer:** **Date:**
Meningitis	/ /					**Mumps Serology**	**Titer:** **Date:**
Hepatitis B	/ /					**Rubella Serology**	**Titer:** **Date:**
Varicella	/ /					**TB Screening (Mantoux)**	
HIB (Preschool)	/ /					**Tested** _____	
Influenza (Preschool)	/ /					**Read** _____	
Pneumonia (Preschool)	/ /					**Result** _____	
Other	/ /						
Other	/ /						

PLEASE COMPLETE BOTH SIDES

SN#19
3/16

PHYSICAL EXAMINATION FINDINGS

(To be Completed by the Physician/Physician Assistant/Nurse Practitioner)

Name:_____ **Date of Exam:**_____

Height:_____ Weight:_____ Blood Pressure:_____ Pulse:_____

Vision: R 20/____ L 20/____ Corrected? Yes/No Hearing:_____

Note any deviation from normal:

Heart:_____ Murmur: Yes/No
Teeth:_____
Lymph Glands:_____
Thyroid:_____
Lungs:_____
Abdomen:_____
Hernia: Yes/ No
Skin:_____
Speech:_____

Ears:_____
Nose/Mouth/Throat:_____
Genito-urinary:_____
Orthopedic: Structural_____
Posture_____
Feet_____
Scoliosis Yes /No
Nutrition:_____
Nervous System:_____

General Appearance:_____
List of Allergies (past and present):_____
_____
Past Illnesses/Operations:_____
_____
Past Injuries:_____
_____
Current Health Problems:_____
_____
Current Medications:_____
_____

Please summarize your medical and developmental findings based upon your physical exam:

_____
_____
Please note any apparent emotional and developmental findings:_____
_____
Educational relevance of findings:_____
_____
Physical Education Restrictions:_____

(Please print, type or stamp)

_____
(Physician Signature)

_____
(Date of Exam)

Physician Name:_____
Address:_____
_____
Telephone:_____
License #:_____