

PARSIPPANY-TROY HILLS TOWNSHIP SCHOOLS

HEALTH SERVICES

PHYSICAL EXAMINATION FORM

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)

Have you had or do you currently have:

a. Any injury, illness, hospitalization or ER visits since your 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? Y/N
 (i.e. Epipen, Albuterol inhaler, etc.).

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 | 1 st Dose MM/DD/YR | 2 nd Dose MM/DD/YR | 3 rd Dose MM/DD/YR | 4 th Dose MM/DD/YR | 5 th 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

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 | Ears: _____ |
| Teeth: _____ | | Nose/Mouth/Throat: _____ |
| Lymph Glands: _____ | | Genito-urinary: _____ |
| Thyroid: _____ | | Orthopedic: Structural _____ |
| Lungs: _____ | | Posture _____ |
| Abdomen: _____ | | Feet _____ |
| Hernia: _____ | Yes/ No | Scoliosis _____ Yes /No |
| Skin: _____ | | Nutrition: _____ |
| Speech: _____ | | 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)

Physician Name: _____

Address: _____

(Date of Exam)

Telephone: _____

License #: _____