CLOSTER PRE-SCHOOL PHYSICAL FORM

Name: _____ Birthday: _____ Age: _____
Address: _____ Sex: _____
_____
Telephone: _____ School District: _____ Grade: _____
Parent/Guardian Name: _____

HISTORY: Are any of these medical factors present in this child's history which may have affected growth and development?

	YES	(Use this space for description of factors present.)
Family		
Pregnancy		
Labor		
Delivery/Birth Weight		
Neonatal		
CNS Infection		
Seizures		
Trauma		
Chronic Illness		
Emotional		
Orthopedic		
Significant Allergies		
Physical Problems		
Hospitalizations or Operations		
Other		
Evidence of impulsivity, inattention, hyperactivity		

Special Consultations: (ophthalmological, neurological, otological, psychiatric, endocrine, etc.)
Name: _____ Date: _____
Summary of findings: _____

VACCINE TYPE	DISEASE DATE	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	Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS – DPT (If DT or Td indicate in corner of box)							
POLIO ORAL POLIO VACCINE (OPV) If Salk Vaccine, indicate (IPV) in corner box							
MEASLES, MUPMPS, RUBELLA (MMR)							
VARICELLA							
HEPATITIS B							
HAEMOPHILUS B (HIB)							
INFLUENZA							
PREVNAR (PNEUMOC)							

MANTOUX	Tested	Read	Result (MM)	CXR (date)	Normal	Abnormal

Screening **Date:** _____
HT: _____ WT: _____ BP: _____ Vision: R 20 / _____ L 20 / _____ Hearing: R _____ L _____
WITH / WITHOUT GLASSES

REPORT OF MEDICAL EXAMINATION

To Be Completed by Physician:

Eyes	_____	Speech	_____	Genitalia	_____
Ears	_____	Heart	_____	Extremities	_____
Nose	_____	Lungs	_____	Abdomen	_____
Skin	_____	Hernia	_____	Other	_____
Throat	_____	Nervous System	_____		_____
Orthopedic	_____	Scoliosis	_____		_____

Laboratory:

Hemoglobin _____ Urine _____ ALB _____ GLUCOSE _____

Other Tests _____

Special Tests (EEG, EKG, Radiology, etc.)

Test: _____ Date: _____

Findings: _____

_____

Please attach copies of consultant's findings.

Is there a history of convulsions or seizures? If yes, please explain Yes _____ No _____

_____

_____

Present Medications	**Dosage**	**Dated Started**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is medication required during school hours? Yes _____ No _____

Future therapy or tests planned: _____

When should this child be examined again? _____

Diagnostic impressions: _____

Summary of health findings which would have an effect on the pupil's learning processes and any care or restrictions with regard to health, safety, and physical education. (If no specific medical problems or restrictions exist, please indicate.)

_____

_____

_____

_____

Physician's signature:

_____

Date: _____

Please print or stamp

Physician's name: _____

Address: _____

Phone number: _____

PLEASE COMPLETE ALL APPLICABLE INFORMATION AND RETURN TO:

Hillside Elementary School
340 Homans Avenue
Closter, NJ 07624