SCHOOL DISTRICT OF THE CHATHAMS, CHATHAM, NEW JERSEY

PHYSICAL EXAMINATION REPORT (To be completed by Physician)

Please complete both sides

Circle Grade: Pre-K K 1 2 3 4 5 6 7 8 9 10 11 12

Student's Name ____ Date of Birth _________________

Address: ___________________________________ Phone: ____________________ School: ____________________

Health History

Allergies: ___________________________________ Diseases: ______ Chicken Pox (Year________), ______ Pertussis (Year______), ______ Strep, ______Lyme Disease (Year______), ______ Diabetes, ______ Heart Disease, ______ Asthma, ______ Mononucleosis, ______ Convulsive Disorder, Others (please specify) ____

To be completed by Physician: **Date of Examination:** _____________

Height: ________________________ Weight: ______________ Blood Pressure: _________________

	Normal	Abnormal	Needs Follow-up	Not Examined
Ears				
Eyes				
Lymph Glands				
Thyroid				
Nose				
Throat				
Teeth-Mouth				
Heart				
Lungs				
Abdomen				
Hernia				
Genito-Urinary				
Orthopedic				
Scoliosis				
Skin				
Nutrition				
Nervous System				
Speech				
General Appearance				

Remarks: ____

May this pupil participate in the entire PHYSICAL EDUCATION PROGRAM? If not, please state reason:

____

____

May this pupil participate in Physical Education related activities such as Football, Soccer, Basketball, Cross country, Track, Wrestling, Tennis, Golf, Lacrosse, Aerobics, Gymnastics, and Weight Lifting?

Yes ____________ No _____________

Does student have any health conditions currently requiring treatment?

___No ___ Yes (Specify): ____________________________________

____ ____

Physician (Print or Stamp) *Physician Signature*

(OVER)

Student: ________________________________ **Date of Birth:** ______________________

IMMUNIZATION HISTORY

Please print clearly or attach a separate Immunization Report

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	Mo/Day/Yr
DIPTHERIA, TETANUS, PERTUSSIS *(If Td or DT, indicate in box)	☐ / /	☐ / /	☐ / /	☐ / /	☐ / /	☐ / /
POLIO-INACTIVATED POLIO (If oral vaccine, indicate OPV in box)	☐ / /	☐ / /	☐ / /	☐ / /	☐ / /	☐ / /
MEASLES, MUMPS, RUBELLA (MMR)	/ /	/ /	/ /	History of Disease or Titer		
MEASLES	/ /	/ /	/ /			
RUBELLA	/ /	/ /	/ /			
MUMPS	/ /	/ /	/ /	Hepatitis B	Date:	Titer:
HAEMOPHILUS B (HIB)**	/ /	/ /	/ /	Varicella	Date:	Titer:
HEPATITIS B	/ /	/ /	/ /	Measles	Date:	Titer:
VARICELLA	/ /	/ /	/ /	Mumps	Date:	Titer:
PNEUMOCOCCAL CONJUGATE**	/ /	/ /	/ /	Rubella	Date:	Titer:
MENINGOCOCCAL	/ /	/ /	/ /	/ /		
HEPATITIS A***	/ /	/ /	/ /	/ /		
HPV*** (HUMAN PAPILLOMAVIRUS)	/ /	/ /	/ /	/ /		
OTHER	/ /	/ /	/ /	/ /		

*REQUIRES MEDICAL EXEMPTION **REQUIRED FOR DAY/CHILD CARE ENROLLEES (2 months-5th birthday only)
***NOT REQUIRED

_____________________________________ _____________________________________

Physician (Print or Stamp) *Physician Signature*

(OVER)