PATERSON PUBLIC SCHOOL PHYSICAL EXAMINATION FORM **DATE OF EXAM**___________

PATERSON PUBLIC SCHOOL # ____________________ **SCHOOL NURSE: 973-321-**____________

DATE GIVEN__________ **DUE BACK**__________ **TIME**__________ **DATE RETURNED**__________

STUDENT NAME:____________________ **DOB:**__________ **AGE:**______ **SEX: M F GRADE:**______

ADDRESS:____________________ **PATERSON, N.J.**__________

HISTORY OF ILLNESS OR ABNORMALITIES:____________________

Vision (R) 20/______ (L) 20/______ **Corrected** Y / N **Glasses:** Y / N **Contacts** Y / N **Hearing** (R)______ (L)______

Height ______ % ______ **Weight** ______ % ______ **B/P** ______ / ______ **Pulse** ______ bpm

Allergies ____________________

Asthma ____________________

Ears____________________ **Eyes**____________________

Lymph Glands____________________ **Thyroid**____________________

Nose____________________ **Throat**____________________

Teeth ____________________ **Mouth**____________________

Heart____________________ **Murmur** ☐ Yes ☐ No

Lungs ____________________

Abdomen____________________ **Hernia**____________________

Genito-Urinary____________________

Orthopedic: Structural__________ **Posture**__________ **Feet**__________ **Scoliosis** __________

Skin____________________ **Nutrition**____________________

Nervous System ____________________

Speech ____________________

General Appearance____________________ **Other**____________________

What if any modifications are required for full participation in the school program?____________________

____

What medical factors may effect his/her growth, development and/or academic progress?____________________

____

Is the child receiving medication ? ____________________ **Other therapy?**____________________

If so, what are the side effects with regard to his/her academic progress in school?____________________

Referrals made as a result of this examination:____________________

____

PHYSICIAN'S SIGNATURE____________________ **TELEPHONE**__________

ADDRESS____________________ **FAX**__________

PRINT PHYSICIAN'S NAME____________________

IMMUNIZATIONS:

DTP/ DTaP /Td	POLIO	MMR	HEP B	HIB	BCG
1.______	1.______	1.______	1.______	1.______	1.______
2.______	2.______	2.______	2.______	2.______	**OTHER**
3.______	3.______	3.______	3.______	3______	______
4.______	4.______	4.______	4.______	4.______	______
5.______	5.______	**VZV**	Varicella Disease Statement or Laboratory Evidence Attached ☐		
Tdap	**MENINGOCOCCAL**	1.______	**OTHER:**______		
1______	1.______	2.______	______		

PPD Mantoux Test: Planted__________ Read__________ Result__________ mm

CXR: Y / N Date:__________ Result:__________ INH: Y / N __________ mg. X __________ mos. Date started: __________ Date Completed __________

Blood Lead Level__________ mcg/dL Date Tested__________ Not Available__________ REFERRED TO FOR TESTING__________

'R-7
03/12ec

☐ YES ☐ NO **ASTHMA TREATMENT PLAN SENT** ☐ YES ☐ NO **ASTHMA TREATMENT PLAN RETURNED**

ENTERING SCHOOL ______________ FROM SCHOOL _______________	**PATERSON PUBLIC SCHOOLS** HEALTH HISTORY APPRAISAL **(El Formulario de la Historia de la Salud)**	GRADE ____________ ACADEMIC YEAR ________ - ___________

Name of Student (Nombre de Estudiante)	**Date of Birth** (Fecha de Nacimiento)	**Gender:** ☐ **M** / ☐ **F** / ☐ **X**

Yes (Si)	**No (No)**	**Please indicate whether the student suffers from any of the conditions listed below** (Por favor indique si el estudiante sufre de cualquier condicion de la lista abajo)			
		Allergies (Alergias)	**Type** (tipo)	**Medication** (medicamento)	**Need to be taken in school** (necesita tomar en escuela) **Yes/Si** **No** (elije uno)
		Asthma (Asma)	**Triggers** (los disparadores)	**Medication** (medicamento)	**Need to be taken in school** (necesita tomar en escuela) **Yes/Si** **No** (elije uno)
		Other Medications (Otras medicinas)	**Type/Dose** (tipo/ dosis)	**Purpose** (el proposito)	**Need to be taken in school** (necesita tomar en escuela) **Yes/Si** **No** (elije uno)
		Accidents/Injuries (Accidents/heridas)	**Date** (fecha)	**Type of Injury** (tipo de herida)	**Complications** (complicaciones)
		Hospitalization (Hospitalizacion)	**Date** (fecha)	**Reason** (razon)	**Complications** (complicaciones)
		Congenital Abnormalities (Defectos congitos)	**Date** (fecha)	**Type** (tipo)	**Limitations** (limitaciones)

Please indicate whether your child has any of the conditions below:
(Por favor indique si su hijo tienes cualquier conidcion de la lista abajo)

	Yes (Si)	**No (No)**		**Yes (Si)**	**No (No)**		**Yes (Si)**	**No (No)**
ADD/ADHD (trastorno de atención)			**Fainting** (desmallos)			**Lupus** (lupus)		
Autistic Spectrum (autismo)			**Gastric Disorder** (desorden astrointestinal)			**Migraines** (migranas)		
Behavior Problems (comportamiento)			**Glasses/Vision** (problemas de vision)			**Nose Bleeds** (sangrado de la nariz)		
Blood Disorder (problema de sangre)			**Hearing Loss** (perdida de sonida)			**Orthopedic Disorder** (trastornos ortopedicos)		
Concussion (concusion)			**Heart Disease** (enfermedad del corazon)			**Psychiatric Disorder** (dificultades mentales/emocionales)		
Convulsive Disorder (trastorno convulsivo)			**Heart Murmur** (soplo en el corazon)			**Scoliosis** (escoliosis)		
Dental Problem (desorden de dientes)			**Hepatitis** (hepatitis)			**Sickle-Cell Disease** (anemia de celulas falciformes)		
Developmental Delay (retrasos en el desarrollo)			**Immune Disorder** (desorden inmune)			**Speech Defect** (defecto del discurso)		
Diabetes (diabetes)			**Kidney Disease** (enfermedad de los rinones)			**Toileting Problem** (problema para ir al baño solo)		
Eczema (eczema)			**Lead Poisoning** (envenenamiento de plomo)			**Other** (otro enfermedad)		

Explanation of any "YES" answers above (explicación de cualquier respuesta de "sí" como se indicó anteriormente):

Parent/Legal Guardian Signature (Firma de Padres/Guardianes): _________________________________ **Date:** ___________

Nurse Signature: _______________________________________ **Date:** _________________

OFFICE OF THE SUPERINTENDENT OF SCHOOLS
PATERSON PUBLIC SCHOOLS
PATERSON, NEW JERSEY

PHYSICAL EXAMINATION

N.J.A.C. 6A:16-2.2 & N.J.S.A. 18A:40-4 requires that each student, upon entry into the school district, shall have a medical examination conducted at the medical home of the student, and a report sent to the school nurse. The complete physical examination shall be documented on the approved school district form and shall include the immunizations, medical history including allergies, past serious illnesses, injuries and operations, medications and current health problems, health screenings including height, weight, hearing, blood pressure and vision. This examination must be completed no more than 365 days prior to school entry and must state what, if any, modifications are required for full participation in the school program.

Recommended subsequent medical examinations shall be conducted at the medical home and a report sent to the school at least one time during each developmental stage at early childhood, pre-adolescence, and adolescence. (Recommended grades: Kindergarten, 4th grade, 8th grade, 10th grade.)

A student shall be examined pursuant to a comprehensive child study team evaluation and when applying for working papers.

A physical examination of each candidate for a school athletic squad or team shall be conducted within 365 days prior to the first practice session. This examination must be documented on the approved New Jersey Department of Education Athletic Pre-Participation Physical Examination form.

In-school health screenings, including height, weight, vision, hearing, blood pressure, strip to the waist biennial scoliosis screening and referral will be conducted by the school nurse and the school physician.

A copy to this signed consent/notification form will be kept with your child's health records.

Student's Name: ________________________________ **Date of Birth:** _______________ **Grade:** ______

Signature of Parent/Legal Guardian: _________________________________ **Date:** _____________

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EXAMENES FISICOS

N.J.A.C. 6A:16-2.2 & N.J.S.A. 18A: 40-4. Todos los estudiantes que entran a un distrito escolar deben tener un examen medico, hecho por el medico de la familia del estudeante, y deben enviar un reporte a la enfermera de la escuela. Este examen fisico completo debe ser documentado en un formulario del distrito y debe incluir las vacunas, historia medica incluyendo alergias, enfermedades serias del pasado, heridas y operaciones, ademas de medicinas y actuales problemas de salud, examnes de salud como altura, peso, audicion, presion sanguinea y vision. Este examen debe haber sido completado no mas de 365 dias antes del la matricula y debe indicar si se requieren modificaciones para participar plenamente en el programa escolar regular.

Un estudiante debe ser examinado tambien de acuerdo a lo que indique un equipo de estudio escolar, o cuando solicite documentos para trabajar.

Un examen de cada candidato para un equipo atletico escolar deber ser conducido dentro de los 365 dias antes de la primera practica de entrenamiento. Este examen debe ser documentado en el Formulario de Examen Fisico de Preparticipacion Atletica del Departmento de Educacion de New Jersey.

Todos los subsecuentes examenes medicos deben ser hechos por el medico de la familia y enviar un reporte a la escuela por lo menos una ves en cada estapa de desarrollo en la Ninez, Pre-adolescencia, y Adolescencia (Grado recomendados: Kindergarten, Grado 4, Grado 8 y Grado 10).

Los examenes de salud en la escuela tales como el de altura, peso, vision, audicion, presion sanguinea, examen bienal de escoliosis y referencias seran conducido por la enfermera de la escuela y/o el medico de la escuela.

Una copia de este Permiso firmado sera guardado junto a los records de salud de su hijo o hija.

Estudiante: ________________________________**Fecha de nacimiento:** _______________ **Grado:** ______

Firma de Padres/Guardianes: _________________________________ **Fecha:** __________