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_____

FR-7
03/12ec ☐ YES ☐ NO ASTHMA TREATMENT PLAN SENT ☐ YES ☐ NO ASTHMA TREATMENT PLAN RETURNED