

The Public Schools
West Orange, New Jersey 07052
PUPIL HEALTH EXAMINATION

NAME: _____ SEX: _____ DATE OF BIRTH: _____
(Last) (First)

SCHOOL OF ATTENDANCE: _____ GRADE: _____

HEALTH HISTORY

Pertinent Medical History: _____

Allergies: _____ Type of Reaction: _____

Treatment/Medication: _____

Is this child on Medication? ____ Yes ____ No If yes, please specify the type and reason for taking: _____

Latest Immunizations (Dates): Hep. B #1 _____ #2 _____ #3 _____ DTP _____ DT _____

OPV/IPV _____ MMR _____ Varivax _____

Meningococcal Vaccine _____ Influenza Vaccine _____ Other _____

Mantoux Tuberculin Test: Date _____ Neg. _____ Pos. _____ mm induration

If positive, result of x-ray _____ Treatment _____

PHYSICAL EXAMINATION

Height _____ Weight _____ Blood Pressure _____

Head _____ Heart Rate _____ Murmurs _____

Ears _____ Hearing : R _____ L _____ Lungs _____

Face _____ Abdomen _____

Eyes _____ Vision: R _____ L _____ Extremities/Orthopedic _____

Nose _____ Both _____

Mouth _____ Corrected – Glasses/Contacts _____ Central Nervous System: _____

Teeth _____ R _____ L _____

Throat _____ Both _____ Genitalia _____

Neck _____ Scoliosis Screening Neg. _____ Pos. _____

Scalp _____ If positive, x-ray _____

Skin _____ Treatment _____

SUMMARY:

RECOMMENDATION: Student may participate in all physical education activities Yes _____

No _____

Student may not participate in the following physical activities: _____

1. Laboratory Work (if indicated): _____ Urinalysis _____ Blood Work-Up _____

2. Other Medical Recommendations: _____

Signature: _____

Date of Physical: _____

Examiner name and title: _____

Check One: ____ School Physician

Address: _____

____ Private Physician

Telephone: _____

____ Advanced Practice Nurse