WEST ORANGE PUBLIC SCHOOLS

179 Eagle Rock Avenue **West Orange, New Jersey 07052**
Department of Student Support Services (973) 669-5400 ext. 20538 Fax: (973) 669-8601

PUPIL HEALTH EXAMINATION

Name _____ Gender _____ 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 Type of Medication & Reason: _____

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

OPV/IPV _____ MMR _____ Varivax _____ Pneumococcal _____ Hepatitis A _____

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 _____	Both	
Nose		Corrected - Glasses / Contacts			
Mouth		Extremities/Orthopedic			
Teeth		Central Nervous System			
Throat		Genitalia			
Neck		Scoliosis Screening		Neg. _____ Pos. _____	
Scalp		If positive, x-ray			
Skin		Treatment			

SUMMARY:

_____

RECOMMENDATION: Student may participate in all physical activities Yes _____ No _____

Student may not participate in the following physical activities: _____

Laboratory work (if indicated) _____ Urinalysis _____ Blood work-up _____

Other Medical Recommendations: _____

Signature _____ Date of physical _____

Examiner Name and Title _____ Check one _____ School Physician

Address _____ _____ Private Physician

Telephone _____ _____ Advanced Practice Nurse

West Orange Public Schools
Emergency Information Form

Student Information

Name	Birth Date	Gender	School Year
Address	School	Grade	Teacher

Parent/Guardian Information

Name	Email	Cell Phone
Relationship: ☐Mother ☐ Father ☐Guardian	Home Phone	Work Phone
Name	Email	Cell Phone
Relationship: ☐Mother ☐ Father ☐Guardian	Home Phone	Work Phone

Emergency Contact Information

Name	Relationship	Cell Phone
	Home Phone	Work Phone
Name	Relationship	Cell Phone
	Home Phone	Work Phone

Siblings Attending West Orange Public Schools

Name	School	Grade

Other Student Information

Doctor Name	Doctor Phone	Date of Last Physical Exam

Family Medical History

Conditions/Diseases parent(s) or sibiling(s) had or currently have (please check all that apply)

☐Significant allergy ☐Rheumatic fever ☐Heart disease ☐Diabetes ☐Tuberculosis ☐Convulsive disorder ☐Cancer ☐Mental illness ☐Other

If any box is checked, Explain:

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?

☐ YES My child has health insurance.

☐ NO My child does not have health insurance.

Signature: _____ Printed name: _____ Date: _____

Written consent required pursuant to 20 U.S.C. § 1232g(b)(1) and 34 C.F.R. 99.30(b).

NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit www.njfamilycare.org to apply online or call 1-800-701-0710.

I will provide for my student's school nurse to hold his/her medication/treatment should he/she ever require medication/treatment as described. ☐ YES ☐ NO

I understand that any changes stated on this card regarding my child's health history needs to be communicated to the school nurse/principal. I also give permission for the release of information for confidential use in meeting my child's health and educational needs in school. I the undersigned, do herby authorize officials of West Orange Public Schools to contact directly the person(s) named on this card and o authorize the named physicians to render such treatment as may be deemed necessary in an emergency for the health of said child. In the event that the contact persons named on this card, or parents/guardians cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Signature: _____ Printed name: _____ Date: _____

Health Conditions	Yes	No	Explanation if Yes
Medication Allergies			List: Reaction:
Food Allergies			Food(s): ☐peanut ☐dairy ☐eggs ☐celiac/other _____ Reaction: Rate severity: ☐mild ☐moderate ☐life-threatening Requires EpiPen? ☐yes ☐no
Allergy to Bees Stings			Rate the reaction: ☐mild ☐moderate ☐life-threatening Does your child require an EpiPen? ☐yes ☐no
Allergies (other)			List:
Asthma/Reactive Airway			Rate severity: ☐mild ☐moderate ☐life-threatening Asthma medication(s) taken at home: Medication(s) required at school:
Diabetes			☐Type 1 (Insulin Dependent) ☐Type 2 Diabetes medication(s):
Seizure Disorder			Type of seizure: Medication(s): Date of last seizure:
ADD/ADHD			Treatment/Medication(s):
Neurological Disorder			Specify:
History of concussion/Head injury			How many? Date of last episode:
Chickenpox			Date:
Heart Condition			Specify:
Blood Disorder/Tendency to bleed easily			Specify: Treatment: Date of last nose bleed:
Cancer			Specify: Treatment:
Bowel/Bladder Issues			Specify:
Migraine Headaches			Triggers: Treatment:
Bone/Muscle Problems			Specify: Activity Restrictions:
Breath Holding/Temper Tantrums			Date of most recent occurrence:
Mental Health/Behavioral Issues			Specify: Treatment/Medication(s):
Wears Glasses/Contacts			☐Glasses ☐Contacts ☐For distance ☐For reading
Hearing Loss			☐Right ear ☐Left ear ☐Hearing Aid(s)
Frequent Ear Infections			Date of most recent occurrence:
Trouble with Speech			Describe:
Other Serious Illness/Injury			Specify: Date of Onset:
Surgery/Hospitalization(s)			Specify: Date(s):
Other Conditions/Restrictions			Specify:
Meditation taken at Home			List - if not already listed: