Rev 9/10

Haddon Township Public Schools
Haddon Township, NJ

NAME: ______________________________ DOB: __________Male [ ] Female [ ] EXAM DATE: ____________

ADDRESS: ________________________________SCHOOL: ________________________GRADE: _______

PHYSICAL EXAMINATION: Height: ____________ Weight: ____________ Blood Pressure: ______________
Vision Screening: Right ____________ Left _____________ with correction: glasses contact lens
Hearing Screening: Right ____________ Left _____________ hearing aid: left right both

Eyes ________ Chest ________ Genito-Urinary ________ Skin ________
Ears ________ Heart ________ Musculoskeletal ________ Speech ________
Nose ________ Lungs ________ Scoliosis ________ Nutrition ________
Mouth/teeth ________ Abdomen ________ Feet ________
Neck ________ Hernia ________ Nervous system ________ Other ________________

General Health: ____
Abnormal/significant findings: ____

MEDICAL HISTORY: Gestational age & birth weight ____
Cardiac (heart murmur, etc.) ____
Operations (procedure & date) ____
Fractures (site & date) ____
Allergies (foods; drugs; environmental) ____
Chronic Illness (asthma, diabetes, ADD, OCD) ____
Medications for Illness/Allergy: ____

Check all that apply & indicate date of illness/diagnosis:

Chicken Pox ________ Measles ________ German Measles ________ Mumps ________ Strep ________
Otitis Media ________ Pertussis ________ Meningitis ________ Rheumatic Fever ________
Hepatitis ________ Mononucleosis ________ Tuberculosis ________ Arthritis ________ Seizures ________
Other ____

IMMUNIZATION RECORD: Please attach copy of clinic/doctor's office record or complete below with *month/day/yr*

DTP, DTaP (Indicate Type) (1) __________ (2) __________ (3) __________
Td, Tdap Boosters (4) __________ (5) __________ (6) __________
OPV or IPV (Indicate Type) (1) __________ (2) __________ (3) __________
Boosters (4) __________ (5) __________
MMR (1) __________ (2) __________ Measles __________ Mumps ________ Rubella ________
Hib (1) __________ (2) __________ (3) __________ (4) __________
HepB (1) __________ (2) __________ (3) __________ HepA (1) __________ (2) __________
Varicella (1) __________ (2) __________ Meningococcal (1) __________ (2) __________
Pneumococcal (1) __________ (2) __________ (3) __________ (4) __________ (5) __________
Influenza (1) __________ (2) __________ (3) __________ (4) __________ (5) __________
Other (specify): ____
Mantoux Test ***(date/result)***: ____

SUMMARY/RECOMMENDATIONS: ____
____

________________________________ ________________________ __________
PHYSICIAN'S SIGNATURE PLEASE PRINT PHYSICIAN'S NAME DATE
(Stamp or Office Staff Initials Not Acceptable)
____
Address and Phone Number

PARENT: Are there special concerns we should be aware? ____
____