PRE-SCHOOL PHYSICAL EXAMINATION AND IMMUNIZATION RECORD

Name _____ Date of Birth _____

Physical examination record

Height_____ Weight_____

Blood pressure_____ Pulse_____

Vision (r)_____(l)_____ Hearing (r)_____(l)_____

Eyes_____ Lungs_____

Ears, Nose, Throat_____ Abdomen_____

Mouth and teeth_____ Skin_____

Neck_____ Genitals/Hernia_____

Heart_____ Extremities_____

Allergies_____ Restrictions from activities_____

Recommendations:_____

_____

Pre-school immunizations ** Required*

8 is *recommended* for pre-school entrance (will be required for **kindergarten**).

Type of Vaccine	**Dose 1**	**Dose 2**	**Dose 3**	**Boosters**
1 DPT/DTaP	*	*	*	*
2 POLIO	*	*	*	
3 MMR	*			
4 VARICELLA (chicken pox)	* one dose *or* disease			
5 HIB	*			
6 INFLUENZA (before Dec. 31st)	*			
7 PNEUMOCOCCAL 8 # Hepatitis B	*			

*Doctor's Name (PRINT)*_____

*Doctor's Address*_____ *Telephone*_____

*Doctor's Signature*_____ *Date of Exam*_____

_____

HEALTH HISTORY

Physical Examination: Required for students entering preschool, kindergarten and those transferring frc of-state or out-of-country. The physical examination is one that was done no more than 365 days prior to into a school or grade.

In grades 1 through 12, only an official school record from the child's former school or a statement fro physician showing documentation of immunization dates will be accepted.

To Be Completed by Parent/Guardian

New Jersey requires that all pupils attending public and private schools receive designated immunizations against disease. These may be waived with a written statement by a licensed physician or religious authority if a certain immunization is medically contraindicated (not able to be given to a child), or if the practice interferes with the fre of the pupil's religious rights. Please check the appropriate box if you desire a waiver form.

☐ Medical contraindication ☐ Religious exemption

Student Name: _____ D.O.B: _____ Gender

Address: _____

Show date child had any of the following *diseases*.

Chicken Pox: _____ Scarlet Fever: _____ Pneumonia: _____

Other (specify): _____

Does your child have any medical history of the following? If so, include date and attach explanation.

Allergies: _____ Asthma: _____

Food Allergies: _____ Drug Sensitivities: _____

Strep Infections: _____ Heart Condition: _____

Seizure Disorders: _____ Fractures: _____

Scoliosis: _____ Diabetes: _____

Kidney Disorder: _____

Vision Difficulties: _____ Wears Glasses: _____ Contacts: _____

Hearing Impairment: _____ Frequent Ear Infections: _____

Tubes in Ears: _____

Speech Problems: _____

Emotional Difficulties: _____

Current Medications: _____

Please note any other pertinent medical information or comments you may have regarding your child's h

_____

_____

Parent's Signature: _____

-OVER-