MENDHAM TOWNSHIP SCHOOLS

PHYSICAL EXAMINATION/IMMUNIZATION RECORD

Child's name (last)_____(first)_____B.D._____Sex_____

Height_____Weight_____Date Of Examination_____

CHECK IF THERE IS A PROBLEM/ABNORMALITY

Nose_____Spine_____Lungs Vision Glasses
Throat_____Chest_____Gums/teeth_____near_____yes_____
Abdomen_____Genitals_____Glands_____far_____no_____Feet_____Skin
Nutrition_____Hearing
Blood pressure_____Heart_____right_____
Healthy child? Yes_____No_____left _____
Allergies_____
Required Daily Medications_____
Special Problems/Physical Restrictions_____
Student may participate fully in all school programs including Physical Ed._____

IMMUNIZATIONS	**DATES**	**IMMUNIZATIONS**	**DATES**
*DPT 1	_____	POLIO—(OPV) OR(IPV)	
*DPT 2	_____		
*DPT 3	_____	*1_____	_____
*DPT/DTaP 4	_____	*2_____	_____
*DTP/DTaP 5	_____	*3_____	_____
(on or after 4th birthday)		*4_____	_____
		(On or after 4th birthday)	
Tdap	_____		
(On or after 11th birthday)			
MMR# 1	_____		
*(on or after first birthday)		* HIB_____	2_____3_____
MMR# 2			4_____5_____
*(on or after fourth birthday) _____		*Varicella	#1_____#2_____
Tuberculin Test:			
(Type) Mantoux____Tine_____		* HBV	
(result) _____		#1_____#2_____#3_____	
Meningococcal_____		Pneumococcal _____	
(Entering Grade 6)			
____ ____ ____ ____ _____ _____ _____			
Hepatitis A _____			
*			

_____
Physicians signature
See school nurse for medical or religious exemptions

NAME:_____(To be filled out by parent)

CHILD'S HEALTH HISTORY

PRENATAL AND BIRTH HISTORY

Problems during pregnancy_____Full term?_____
Length of labor_____Type of delivery: normal, forceps, caesarean
Condition at birth: normal_____jaundiced_____, cyanotic_____
Birth weight_____

DEVELOPMENTAL HISTORY: *Please record any developmental problems (i.e. delayed speech, poorcoordination)*

_____

_____

MEDICAL HISTORY: *Please check and include dates if possible.*

Communicable diseases: Chicken pox_____Scarlet fever_____
Measles_____Mumps_____
Other Illnesses: Strep infections_____, Tonsillitis_____, Lyme Disease _____
Frequent colds_____, ear infections_____, other_____
Surgical procedures:_____

_____
Injuries: (i.e. fractures concussions)_____
Physical limitations: _____
Allergies:_____
Deficiencies: Vision_____, Hearing_____, Speech_____
Eyes examined by an eye specialist?_____If so, when_____
Wearing glasses?_____
Date of most recent dental check-up_____Dentist Name_____

HEALTH HABITS: Please check any that cause parental concern:
Elimination_____, Bedwetting_____Diet_____Appetite_____
Fears_____Peer relations_____
Sibling rivalry_____Temper tantrums_____
Sleep_____Other_____
Indicate # of hours sleep averaged per night_____

MEDICATIONS: Does your child take daily medications?_____
If so, please list: _____
I give the school nurse permission to share pertinent health information with other essential staff members when *it is necessary to assist in meeting the health and educational needs of my child.*

*Signature of Parent or Guardian:*_____