Wall Township School District
Kindergarten/New Student Physical Exam

Name______________________________________ **D.O.B.** ____________________

IMMUNIZATIONS: * Required for school entry

TYPE	PRIMARY SERIES			BOOSTERS		AFTER 4TH B-DAY
DPT	*	*	*	*		*
Tdap (1 dose after 10th BD)						
POLIO	*	*	*			*
MMR	*	*				
MEASLES						
MUMPS						
RUBELLA						
HIB (1 dose pre-school only)						
PCV						
VARICELLA	*					
HEPATITIS A						
HEPATITIS B	*	*	*			
OTHER						
INFLUENZA 1 dose between 9/1 and 12/31 (ages 6 to 59 mo)						
Meningococcal 1 dose for students born after 1/1/97, attending gr. 6						

TB TEST (MANTOUX) TYPE: ________________ DATE: ___________ RESULT: __________

BLOOD LEAD LEVEL (BLL): _________ DATE TESTED: ___________

MEDICAL EXAMINATION

SUMMARY OF SIGNIFICANT MEDICAL HISTORY AND INFORMATION:

____

____

COMPLETE PHYSICAL EXAM:

HT. ____ WT. ____ B.P. _______ VISION (uncorrected) R _____/_____ L _____/_____ GLASSES_______
HEARING: R ___________ L ______________ LOSS? ____________________________
POSITIVE FINDINGS: ____

IS THIS CHILD UNDER TREATMENT FOR ANY CONDITION?____________________________

IS THIS CHILD RECEIVING ANY REGULAR MEDICATION? (NAME, DOSAGE, REASON) __________________

THIS CHILD MAY PARTICIPATE IN PHYSICAL EDUCATION AND SPORTS _______________
RESTRICTIONS: ____
PLEASE COMMENT ON ANY PERTINENT HEALTH PROBLEMS OR PHYSICAL FINDINGS THAT MIGHT ADVERSELY INLUENCE THIS CHILD'S ABILITY TO LEARN OR ENGAGE IN SCHOOL ACTIVITIES:

____

DATE: ____________________ PHYSICIAN SIGNATURE: __________________________
PHYSICIAN NAME (PRINT): __________________________

PHONE: ___________________ ADDRESS: ____

PLEASE RETURN COMPLETED FORM TO SCHOOL NURSE BY _________

Revised 6/2015