

PARSIPPANY-TROY HILLS TOWNSHIP SCHOOLS

HEALTH SERVICES

PHYSICAL EXAMINATION FORM – PRE-K – GRADE 5

Name of Student: _____ Date of Birth: _____
 Sex: M F (circle one) Age: _____ Grade: _____ School: _____
 Address: _____ City, State, Zip: _____
 Home Phone: _____

Health History

(to be completed by the parent)

Has your child had or do they currently have:

a. Any injury, illness, hospitalization or ER visits since their last exam? Y/N

If so, please list: _____

b. Any allergies to foods, bee stings, latex, pollen? Y/N/Don't know

If so, to what? _____

Please describe reaction: _____

c. Does your child currently take any medication prescribed by a doctor or over the counter medication on a daily basis? Y/N

If so, please list: _____

d. Does your child take any medication on an as needed basis? Y/N
 (i.e. Epipen, Albuterol inhaler, etc.).

Please list: _____

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

Parent/Guardian Signature: _____ Date: _____

To be Completed by MD Office

Vaccine Type	Disease MM/DD/YR	1 st Dose MM/DD/YR	2 nd Dose MM/DD/YR	3 rd Dose MM/DD/YR	4 th Dose MM/DD/YR	5 th Dose MM/DD/YR	Booster MM/DD/YR
DPT/DtaP/TdaP (Indicate type)	/ /						
IPV (indicate if OPV)	/ /						
MMR (indicate if separate vaccine)	/ /					Measles Serology	Titer: Date:
Meningitis	/ /					Mumps Serology	Titer: Date:
Hepatitis B	/ /					Rubella Serology	Titer: Date:
Varicella	/ /					TB Screening (Mantoux)	
HIB (Preschool)	/ /					Tested _____	
Influenza (Preschool)	/ /					Read _____	
Pneumonia (Preschool)	/ /					Result _____	
Other	/ /						
Other	/ /						

PLEASE COMPLETE BOTH SIDES

PHYSICAL EXAMINATION FINDINGS
(To be Completed by the Physician/Physician Assistant/Nurse Practitioner)

Name: _____ **Date of Exam:** _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision: R 20/____ L 20/____ Corrected? Yes/No Hearing: _____

Note any deviation from normal:

Heart: _____	Murmur: Yes/No	Ears: _____
Teeth: _____		Nose/Mouth/Throat: _____
Lymph Glands: _____		Genito-urinary: _____
Thyroid: _____		Orthopedic: Structural _____
Lungs: _____		Posture _____
Abdomen: _____		Feet _____
Hernia: _____	Yes/ No	Scoliosis _____ Yes /No
Skin: _____		Nutrition: _____
Speech: _____		Nervous System: _____

General Appearance: _____

List of Allergies (past and present): _____

Past Illnesses/Operations: _____

Past Injuries: _____

Current Health Problems: _____

Current Medications: _____

Please summarize your medical and developmental findings based upon your physical exam:

Please note any apparent emotional and developmental findings: _____

Educational relevance of findings: _____

Physical Education Restrictions: _____

(Please print, type or stamp)

(Physician Signature)

Physician Name: _____

Address: _____

(Date of Exam)

Telephone: _____

License #: _____