**The Public Schools**
**West Orange, New Jersey 07052**

# PUPIL HEALTH EXAMINATION

NAME:______________________________________ SEX: _____ DATE OF BIRTH:_______________________
(Last) (First)

SCHOOL OF ATTENDANCE:______________________________________GRADE:___________________________

**HEALTH HISTORY**

Pertinent Medical History: ________________________________________________________________________________

____________________________________________________________________________________________________

Allergies:_______________________________________________ Type of Reaction: ________________________________________________

Treatment/Medication:_____________________________________________________

Is this child on Medication? ____Yes ____No If yes, please specify the type and reason for taking:___________________________________

____________________________________________________________________________________________________

Latest Immunizations (Dates): Hep. B #1______________#2______________#3______________DTP_____________ DT ________________

OPV/IPV________________________ MMR___________________________ Varivax_______________________________

Meningococcal Vaccine________________ Influenza Vaccine__________________ Other________________________________________

Mantoux Tuberculin Test: Date____________________________ Neg.______ Pos._______ ________________ mm induration

If positive, result of x-ray ________________________ Treatment ________________________________________

**PHYSICAL EXAMINATION**

Height___________________________ Weight_______________________ Blood Pressure ____________________________

Head____________________________ Heart Rate_______ Murmurs__________________

Ears ____________________________ Hearing : R_____ L______ Lungs_________________________________________

Face____________________________ Abdomen_______________________________________

Eyes____________________________ Vision: R_____ L _____ Extremities/Orthopedic_______________________

Nose ___________________________ Both ___________________ _________________________________________

Mouth__________________________ Corrected – Glasses/Contacts Central Nervous System: _____________________

Teeth __________________________ R_____ L _____ __________________________________________

Throat__________________________ Both __________________ Genitalia _________________________________

Neck___________________________ Scoliosis Screening Neg. _______ Pos. _________

Scalp___________________________ If positive, x-ray ___________________________

Skin ___________________________ Treatment ________________________________

**SUMMARY:**

____________________________________________________________________________________________________

____________________________________________________________________________________________________

**RECOMMENDATION:** Student may participate in all physical education activities Yes___________

No________________

Student may not participate in the following physical activities:___________________________________________________________________

1. Laboratory Work (if indicated): ______________________________________Urinalysis ________________ Blood Work-Up _________
2. Other Medical Recommendations: _______________________________________________________________________________

____________________________________________________________________________________________________

Signature:________________________________________________________ Date of Physical: _______________________

Examiner name and title: ___________________________________________ Check One: ____ School Physician

Address:_________________________________________________________ ____ Private Physician

Telephone:_______________________________________________________ ____ Advanced Practice Nurse