PARAMUS PUBLIC SCHOOLS Paramus, New Jersey

STUDENT PHYSICAL EXAMINATION FORM

For Grades pre K through 8

All students in Early Childhood, Kindergarten, grades three, six and nine, as well as all new students in Paramus Public Schools, are required to have a physical examination. Please arrange for the necessary examination with your child's health care provider and return this completed form to the school nurse (within 30 days for all new students).

No child will be allowed to participate in physical education classes without this examination and recommendation by the examining healthcare provider.

Name	Date of Birth	Grade						
PHYSICAL EXAM: Height Wei	ght B/P _	Pulse						
Vision without correction: R 20	/ L 20/	Hearing: Right						
with correction: R 20)/ L 20/	Left						
Urine	Hgb/Hct _							
(protein, sugar) Skin – Scalp Acne Eczema								
Eyes: Lids Conjunctiva	Pupils Ea	ars:Canal Eardrum						
Nasal passages Throat	Tonsils	Teeth						
Neck Heart _		Lungs						
Abdomen Hernia	Genitalia _	Menses						
Orthopedic: Posture Spine _	Feet	Extremities						
perations Injuries								
Allergies (include food, drug, insect bites):								
Does student take any medication on a regular or prn basis? ☐ Yes ☐ No								
Name of medication / dosage:	_ Reason							
Significant past illnesses?								
Current and / or health problems (asthma, ADHD, etc.)?								
Significant family medical history								

Full physical education program recommended? ☐ Yes ☐ No

<u>IMMUNIZATION RECORD</u>							
Vaccine	Mo/day/year	Mo/day/year	Mo/day/year	Mo/day/year	Mo/day/year		
OTP/Td Fetanus, diphtheria,& acellular pertussis Tdap) Polio							
MMR							
Measles							
Mumps							
Rubella							
HIB							
Hepatitis B Varivax							
Pneumoccocal Vaccine							
nfluenza Vaccine							
Meningococcal Vaccine							
Other							
Mantoux: Date admir	nistered	Da	nte read				
Results: Negative	e 🗆 Positive	Induration _		mm			
Chest X-Ray: Date		Results					
Medication (if prescribed):							
Date started	Date finished	d	_				
Health Care Provider N	ame / Address	/ Phone (Plea	ise Print or Sta	ımp):			
Health Care Provider S Rev. 1/2008/vh				_ Date of exan	n:		