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 _____ Weight _____ 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_____ Ears:Canal_____ Eardrum _____

Nasal passages _____ Throat _____ Tonsils _____ Teeth _____

Neck _____ Heart _____ Lungs _____

Abdomen _____ Hernia _____Genitalia _____ Menses _____

Orthopedic: Posture _____ Spine _____ Feet _____ Extremities _____

Operations _____ 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**

If not recommended, reason:_____

Educational Relevance of findings, if any _____

Impact of current medical management on student's learning processes, if any _____

_____

IMMUNIZATION RECORD

Vaccine	Mo/day/year	Mo/day/year	Mo/day/year	Mo/day/year	Mo/day/year
DTP/Td					
Tetanus, diphtheria,& acellular pertussis (Tdap)					
Polio					
MMR					
Measles					
Mumps					
Rubella					
HIB					
Hepatitis B					
Varivax					
Pneumoccocal Vaccine					
Influenza Vaccine					
Meningococcal Vaccine					
Other					

Mantoux: Date administered _____ Date read _____

Results: □ Negative □ Positive Induration _____mm

Chest X-Ray: Date _____ Results _____

Medication (if prescribed):_____

Date started _____ Date finished _____

Health Care Provider Name / Address / Phone (Please Print or Stamp):

Health Care Provider Signature: _____ Date of exam:_____

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