

**SCOTCH PLAINS-FANWOOD PUBLIC SCHOOLS  
NEW STUDENT MEDICAL EXAMINATION RECORD**

STUDENT'S NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 SCHOOL \_\_\_\_\_ Grade \_\_\_\_\_

**IMMUNIZATIONS** (to be filled in by the physician)

VACCINE TYPE	1st Dose m/d/yr	2nd Dose m/d/yr	3rd Dose m/d/yr	4th Dose m/d/yr	5th Dose m/d/yr	Month/ Day/Year
Diphtheria, Tetanus, Pertussis (DTP), (Td* or DT*)						
Tdap						
Polio-Oral Polio Vaccine (OPV) (if Salk Vaccine, indicate IPV)						
Measles, Mumps, Rubella (MMR)				XXXXXXXXXX XXXXXXXXXX	XXXXXXXXXX XXXXXXXXXX	XXXXXXXXXXXXXX XXXXXXXXXXXXXX
Measles				Or Serology	date	titer
Rubella				Or Serology	date	titer
Mumps				Or Serology	date	titer
Varicella				Or Serology	date	titer
Haemophilis B (Hib)						
Hepatitis B						
Pneumococcal						
Meningococcal						
Influenza						
Other (specify)						
Other (specify)						

\* Requires Medical Exemption

Provisional Admission Attached Date Granted \_\_\_\_\_ Medical Exemption Attached Date Granted \_\_\_\_\_ Religious Exemption Attached Date Granted \_\_\_\_\_

TUBERCULIN MANTOUX TEST: DATE GIVEN \_\_\_\_\_ DATE READ \_\_\_\_\_ RESULT \_\_\_\_\_

**PHYSICAL EXAMINATION RECORD**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
 Examination Code: "O" = noted or normal, "V" = defect  
 Eyes \_\_\_\_\_ Nose \_\_\_\_\_ Hernia \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Ears \_\_\_\_\_ Throat \_\_\_\_\_ Genitalia \_\_\_\_\_  
 Skin \_\_\_\_\_ Teeth \_\_\_\_\_ Reflexes: \_\_\_\_\_  
 Scalp \_\_\_\_\_ Heart \_\_\_\_\_ Knee \_\_\_\_\_  
 Glands \_\_\_\_\_ Lungs \_\_\_\_\_ Arm \_\_\_\_\_  
 Nutrition \_\_\_\_\_ Spine \_\_\_\_\_ Foot \_\_\_\_\_

Has this child had any acute or prolonged illness, injuries or operations? \_\_\_\_\_

Is this child under any treatment or medication? Yes \_\_\_\_\_ No \_\_\_\_\_ Condition \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Is there a condition that would limit physical activity? \_\_\_\_\_ Type of limitation \_\_\_\_\_

Approximate length of time \_\_\_\_\_

Date of last dental examination \_\_\_\_\_ Braces? \_\_\_\_\_

Does this child wear glasses? \_\_\_\_\_ Contact lenses? \_\_\_\_\_ Eye Doctor: \_\_\_\_\_

Date of last eye examination \_\_\_\_\_ Vision Test: Testing without glasses \_\_\_\_\_ With Glasses \_\_\_\_\_

Glasses to be worn: \_\_\_\_\_ R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_

Audiometric Screening R \_\_\_\_\_ db L \_\_\_\_\_ db

Doctor's Name, Address, Telephone \_\_\_\_\_

**Date of Examination** \_\_\_\_\_ (please print or stamp)

**Physician's Signature** \_\_\_\_\_