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*)						
Polio-Oral Polio Vaccine (OPV) (if Salk Vaccine, indicate IPV)						
Measles, Mumps, Rubella (MMR)				XXXXXXXXX XXXXXXXXX	XXXXXXXXX XXXXXXXXX	XXXXXXXXXXXXX XXXXXXXXXXXXX
Measles				Or serology	date	titer
Rubella				Or serology	date	titer
Mumps				Or serology	date	titer
Varicella				Or serology	date	titer
Haemophilus B (Hib)						
Hepatitis B						
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 _____

5/96 1/01 6/04