HIGH BRIDGE SCHOOL DISTRICT

STUDENT HEALTH AND PHYSICAL EXAM FORM

Directions: *Doctor, APN, PA**, please c***omplete for Pre-K – Grade 4.
For Grades 5-12 a New Jersey Athletic Pre-participation Exam is preferred/necessary for sports participation.

Student's Name:_____ Birth Date:_____

Sex: ___Male ___Female Immunization Registry Number:_____

IMMUNIZATIONS: Please attach vaccine record of student
Influenza: Required for Pre-school only
Tdap & Meningococcal: Required for entrance into 6th grade

Disease History	**Type/Yr**	**History**	**Type/Yr**	**History**	**Type/Yr**	**History**	**Type/Yr**
Allergies		Diabetes		Lyme Disease		Juvenile Rheumatoid Arthritis	
Drug Sensitivities		Influenza		Mononucleosis		Autism Spectrum Disorders	
Non-food/Non-drug allergies		Other		Neuromuscular. Disorder		Hematological Disorders	
Asthma		Drug allergies		Chronic Otitis Media		ADD/ADHD	
Congenital Disorder		Heart Disease		Autoimmune Disorder		Concussion/TBI	
Convulsive Disorder		Hepatitis		Strep Infections		Vision or Hearing Impaired	

TB Testing	Date administered	Date read	Results	Vaccine, BCG date
Mantoux (PPD)				
IGRA				

Operations/Injuries: (Please specify)

1.
2.
3.

Medications:_____
**Kindly provide order if medication is required during school hours.*

Allergies (Drug/Environmental/Food): ___No ___Yes(Describe):_____

Student requires:

Epi Pen ___No ___*Yes *A doctor's order and 2 Epi Pens are needed for school.

Rescue Inhaler ___No ___*Yes *A doctor's order and an inhaler are needed for school.
* Please consider having 5th-8th graders self-administer, related to sports and class trips, if possible.

Student's Name:_____ Date of Exam:_____

Vitals/Screenings

Height:	Weight:	Pulse:	B/P:
Vision: With Correction	Right:	Left:	Both:
Vision: Without Correction	Right:	Left:	Both:
Hearing Screen: Pure tone? Y/N	Right:	Left:	

	Normal Exam	**Abnormal Findings:**
Head		
Eyes		
Ears		
Nose		
Throat		
Lymph Glands		
Heart		
Lungs		
Abdomen		
Hernia		
Genitalia		
Skin		
Orthopedic		
Scoliosis		
Neurological		
Speech		
Nutrition		

Activity Limitation: ___No ___*Yes (**If yes, please define & attach note from doctor if restrictions are required at school):*

_____

Comments:_____

Physician's signature: _____ Date:_____

Physician's Name, Address and Telephone # **Office Stamp**

_____

_____

_____

_____