To Be Completed by the Health Care Provider

Clayton Public Schools

History and Physical Examination

Last Name:______________________________ First Name:______________________________

Date of Birth:______________________________ Gender: Male__________ Female __________

Medical History

Prenatal problems:______________________________

Disease History (Please indicate dates)

Allergies__________________ Asthma__________________ Otis Media__________________

Drug Sensitivities__________________ Asthma Action Plan: ___yes ____no Rheumatic Fever__________________

Lyme Disease__________________ Convulsive Disorder__________________ Strep Infections__________________

Hepatitis__________________ Diabetes__________________ Mononucleosis__________________

Neuromuscular Disorder__________________ Heart Disease__________________ Heart Murmur__________________

Heart Defect__________________ Cancer__________________ Seizures__________________

Chicken Pox__________________ Congenital Anomalies__________________ Pneumonia__________________

Other/Surgical Procedures (list dates):______________________________

Is this child receiving any medications? ______________________________

Immunization History (Please indicate the month, day and year or attach official immunization form)

Vaccine Type	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose
DPT, DT or Dtap					
OPV or IPV					
MMR					
HIB					
Hepatitis B					
Varicella					
Hepatitis A					
Pneumococcal*					
Influenza*					

*Required for Preschool Students only

Country of Birth__________________ **Transferring into NJ from** __________________

If from country with high incidence of TB please test as per NJ Dept. of Health Tuberculosis Program guidelines. Tuberculosis testing for NJ Dept of Education TB Screening as follows:

Mantoux testing Date______________ Results______________________________

IGRA Bloodwork Date______________ Results______________________________

Chest X-Ray: Date______________ Results______________________________

Please complete both sides of form

Student's Name: ______________________________

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Physical Examination

Height______________________ Weight__________________ Blood Pressure_________________

Eyes ______________________________ Ears____

Nose ______________________________ Mouth and Teeth ______________________________

Throat_____________________________ Tonsils/Adenoids ______________________________

Lymph glands_______________________ Skin____

Heart____

Murmur?___________________________ Functional _______________ Pathologic ________________

Any Restrictions? ____

Lungs ____

Musculoskeletal _____________________ Scoliosis __________________________________

Abdomen __________________________ GI/GU _____________________________________

Hernia____________________________ Nervous System ______________________________

Speech ____

Growth and Development ____

Previous serious injuries, illness or deformities ____

Does this child have any physical needs or restrictions that would prevent or limit participation in school activities, including gym and sports activities? ________No ___________Yes

Please Describe ____

____

Hearing Results

Db Level ___________ For each frequency, please indicate: P=Pass F=Fail

	500Hz	1000Hz	2000Hz	3000Hz	4000Hz
Right:	______	______	______	______	______
Left:	______	______	______	______	______

Conclusion: (Please circle one): Pass Fail

Referral made for further testing: (Please circle one): Yes______ No_____

Comments:____

____

Vision Results

Right: 20 / _____ Left: 20 / _____ Both: 20 / _____

If vision screening over 20/30, was referral made: (Please circle one) Yes_____ No______

Physician's Signature_______________________________________ **Date of Exam**____________

Office Stamp: