

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 _____	Otitis 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	1 st Dose	2 nd Dose	3 rd Dose	4 th Dose	5 th 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 _____

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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: