JEFFERSON TWP PUBLIC SCHOOLS

Students Name:_____ M_____F_____ Birth Date(mm/dd/yy) _____Grade_____ Age_____
(Last, First, M.I.)

PHYSICAL EXAMINATION **Blood Pressure** _____

EARS(Otoscopic)_____

HEARING TESTING		RESULT	FOLLOW-UP
DATE	RT		
	LEFT		

EYES_____

STUDENT WEARS: Circle One: Glasses - Contact Lenses - None

VISION SCREENING		RESULT	FOLLOW-UP
DATE	RT		
	LEFT		
	OU		

LYMPH GLANDS_____
SCOLIOSIS_____
THYROID_____
NOSE_____
THROAT_____
TEETH-MOUTH_____
HEART_____
LUNGS_____
ABDOMEN_____
HERNIA_____
GENITO-URINARY_____
Structural_____
ORTHOPEDIC_____
Posture_____ Feet_____
SKIN_____
NUTRITION_____
NERVOUS SYSTEM_____
SPEECH_____
OTHER_____

DISEASE HISTORY	YEAR		YEAR		YEAR
ALLERGIES		DRUG ALLERGIES		NEUROMUSC.DIS	
ASTHMA		HEART DISEASE		OTITIS MEDIA	
CONGENITAL DISORDER		HEPATITIS		STREP INFEC	
CONVULSIVE DISORDER		LYME DISEASE		JUV RHEUM ARTHRITIS	
DIABETES		MONONUCLEOSIS		OTHER	
AUTISTIC SPECTRUM DIS		HEMATOLOGICAL DIS			

Height:	Weight:					
BMI for age Percentile:						
(check)	<5th ( )	5th to 50th ( )	50th to 85th ( )	85th to 95th ( )	>95th ( )	
						Titer/Disease
						*titers attach
IMMUNIZATIONS	**Mo/Day/Yr.of Each Dose**					lab results
* Indicate if DPT, Dtap, or DT	1st	2nd	3rd	4th	5th	Date:
DIPHTHERIA						
PERTUSSIS						
TETANUS						
POLIO(OPV/IPV)						
MMR						
MEASLES						
MUMPS						
RUBELLA						
HAEMOPHILUS B (HIB)						
HEPATITIS B						
VARICELLA						
PNEUMOCOCCAL CONJ						
HEPATITIS A						
MENINGOCOCCAL						
INFLUENZA						
OTHER,SPECIFY						
TB SCREENING / MANTOUX	DATE:		READ:		RESULTS:	
MEDICATIONS	DATE	DOSE	FREQUENCY			
OPERATIONS / INJURIES						
PHYSICAL RESTRICTIONS	*check below					
None						
Specify						
COMMENTS						

DATE EXAM:_____ (PRINT) DR. NAME:_____Phone:_____ DR. SIGNATURE_____

Health form Revised: EAC-2/09