FLEMINGTON RARITAN REGIONAL SCHOOLS
STUDENT HEALTH AND PHYSICAL EXAM FORM
(FOR USE IN GRADES PRE-K TO 4)

Student's Name:_____ **Birth Date:**_____

Sex: □ **Male** □ **Female** **Immunization Registry Number:** _____

DISEASE HISTORY	TYPE/ YEAR	DISEASE HISTORY	TYPE/YEAR
Food Allergies		Mononucleosis	
Non-Food, non-drug allergies		Neuromuscular Disorder	
Asthma		Chronic Otitis Media	
Congenital Disorder		Autoimmune Disorder	
Convulsive Disorder		Strep Infections	
Diabetes		Juvenile Rheumatoid Arthritis	
Influenza		Autism Spectrum Disorder	
Other		Hematological Disorder	
Drug Allergies		ADD/ADHD	
Heart Disease		Concussion/TBI	
Chicken Pox		Vision Disorder	
Hepatitis		Hearing Disorder	
Lyme Disease			

OPERATION/INJURIES (PLEASE SPECIFY):

1.
2.
3.

ADDITIONAL COMMENTS:

IMMUNIZATIONS: PLEASE ATTACH STUDENT'S VACCINE RECORD

Influenza: Required for Pre-School only
Tdap and Meningococcal: Required for entrance into 6th grade

Mantoux (PPD)	**Date administered:**	**Date Read and Results:**	**Vaccine, BCG date**
IGRA			

MEDICATIONS:_____

_____

***** Kindly provide medication order if medication is required during school hours*****

ALLERGIES (Drug/Environmental/Food):

_____

Student Requires Epinephrine: ____No ____Yes→A med order & 2 Epinephrine auto injectors are needed for school
Student Requires Rescue Inhaler: ____No ____Yes→A med order & an inhaler are needed for school.
*******Please consider allowing 5th through 8th grade students to self-administer for sports and class trips*******

Student's Name:_____ **Exam Date**_____

Height:	Weight:	Pulse:	B/P:
Vision:	Uncorrected	Right:	Left:
Vision:	Corrected	Right:	Left:
Hearing Screen:		Right:	Left:

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

Any Limitation of Activity? : □ No □ Yes (Please define):

_____

_____

Physician's Comments and Recommendations:

_____

_____

Physician signature:_____ **Date:**_____

Physician's Name, Address and Telephone #:

_____

_____

_____

_____