Flemington-Raritan Regional Schools
50 Court Street
Flemington, New Jersey 08822

SCHOOL PERSONNEL
HEALTH HISTORY

Name _____ DOB _____

Address _____ SSN _____

_____ Phone _____

Family Physician _____ Phone _____

EMERGENCY INFORMATION

Emergency Contact Name _____

Daytime phone _____ Cell phone _____

Have you had any:	**Yes**	**No**	**Date - Explanation if "yes"**
Serious medical condition			
Serious illness			
Serious injuries			
Hospitalizations			
Surgery/operations			

Have you had:	**Yes**	**No**	**Date - if "yes"**
Chickenpox			
Hepatitis			
Meningitis			
Mononucleosis			
Pneumonia			
Tuberculosis (you or your family)			
Lyme Disease			
Arthritis			
Any other communicable disease			Disease: Date:

Do you have a history of:	Yes	No	Explanation if "yes"
Allergies - medications, food, insect bites, other			
Asthma			
Bleeding disorder			
Bowel problems			
Cardiac (heart) condition			
Congenital (birth) defect			
Convulsions/epilepsy/seizures			
Ear condition or infections			
Eczema/psoriasis/any other skin condition			
Fainting			
Hearing problems			
Kidney or urinary problems			
Muscular problems/diseases			
Neurological problems/diseases			
Orthopedic problems/diseases			
Vision problem/glasses/contacts			
Any other condition requiring on-going doctor's care			
Need to take daily medication			
Need to take emergency meds			

Any "yes" response requires an explanation: _____

_____

_____

_____

_____

_____ _____

Employee Name Date

I give my permission for this information to be shared with the building principal and school nurse.

_____ _____

Employee Signature Date

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SCHOOL PERSONNEL - PHYSICAL EXAMINATION

Name _____ DOB _____

A. Immunizations – Complete all dates (optional)

DPT					
OPV/IPV (specify)					
MMR					
Measles					
Mumps					
Rubella					
Varicella					
HIB					
Hepatitis B					

Mantoux: Date given:_____Date read: _____Results: _____

B. Date of Physical Examination _____Ht. _____Wt. _____BP _____

Select one (X)	**Normal**	**Deviation**	**Explanation**
Ears (otoscopic)			audio R _____ L _____
Eyes			acuity R _____ L _____
Lymph Glands			
Thyroid			
Nose			
Throat			
Teeth/mouth			
Heart			murmur _____
Lungs			
Abdomen			
Hernia			
Genito-Urinary			
Orthopedic: Structural			
Posture			
Scoliosis			
Feet			
Skin (non-communicable)			
Nutrition			
Nervous system			
Speech			
Other			
General appearance			

Examining Physicians' Signature _____Date _____
Physician's Name and Address _____
(please print or stamp) _____
_____