PARAMUS PUBLIC SCHOOLS
Paramus, New Jersey

STUDENT PHYSICAL EXAMINATION FORM

FOR GRADES PRE-K THROUGH 4

All students in Early Childhood, Kindergarten, grades three, six, and nine, as well as all new students in Paramus Public Schools, are required to have a physical examination. Please arrange for the necessary examination with your child's doctor and return this completed form to the school nurse (within 30 days for all new students).

No child will be allowed to participate in physical education classes without this examination and recommendation by the examining healthcare provider.

NAME _____ DATE OF BIRTH _____ GRADE _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Vision Without Correction: R 20/ _____ L 20/_____
Vision With Correction: R 20/ _____ L 20/_____

Hearing: Right _____ Left _____

Urine: _____ Hgb/Hct _____
(protein, sugar)

Skin/Scalp _____ Acne _____ Eczema _____

Eyes: Lids _____ Conjunctiva _____ Pupils _____ Ears: Canal _____ Eardrum _____

Nasal Passages _____ Throat _____ Tonsils _____ Teeth _____

Neck _____ Heart _____ Lungs _____

Abdomen _____ Hernia _____ Genitalia _____ Menses _____

Orthopedic: Posture _____ Spine _____ Feet _____ Extremities _____

Operations _____ Injuries _____

Allergies (include food, drug, insect bites) _____

Does child take any medication on a regular basis? Yes _____ No _____

Name of Medication/Dosage _____ Reason _____

Significant past illnesses _____

Current illnesses and/or health problems (asthma, ADHD, etc.)
_____

Significant family medical history _____

Full Physical Education Program recommended: Yes _____ No _____

If not recommended, reason _____

Educational relevance of findings, if any _____

Impact of current medical management on student's learning processes, if any:
_____

IMMUNIZATION RECORD

VACCINE	M/D/Y	M/D/Y	M/D/Y	M/D/Y	M/D/Y
DPT/Td					
Tetanus, Diphtheria & Acellular Pertussis (Tdap)					
Polio					
MMR					
Measles					
Mumps					
Rubella					
HIB					
Hepatitis B					
Varivax					
Pneumoccocal Vaccine					
Influenza Vaccine					
Meningococcal Vaccine					
Other					

Mantoux : Date Administered _____ Date Read_____

Results: Negative _____ Positive _____ Induration _____mm

Chest X-Ray Date _____ Results _____

Medication (if prescribed) _____

Date Started _____ Date Finished _____

Healthcare Provider Name/Address/Phone (please print or stamp):

Healthcare Provider Signature _____ Date of Exam _____

NJ Minimum Vaccination/Immunization Requirements

Students entering Pre-school, Early Childhood Center

DTaP Vaccine – Minimum of 4 doses

Polio Vaccine – Minimum of 3 doses

Measles, Mumps, Rubella Vaccine – 1 dose given on or after the 1st birthday

Varicella Vaccine – 1 dose given on or after the 1st birthday

HIB_Vaccine-- 1 dose given on or after the 1st birthday

Pneumococcal Vaccine-- 1 dose given on or after the 1st birthday

Influenza Vaccine-- 1 dose given between September 1 and December 31 of each year.

Students entering January 1st- March 31st must have 1 dose since it is still flu season.

Students entering Kindergarten-1st Grade

DTaP Vaccine – A total of 4 doses **if** 1 dose is on or after the 4th birthday **OR** any 5 doses

Polio Vaccine – Minimum of 3 doses **if** 1 dose given on or after the 4th birthday **OR** any 4 doses

Measles Vaccine – 2 doses with the first dose given on or after the 1st birthday

OR documented immunity*

Mumps & Rubella Vaccine – 1 dose given on or after the 1st birthday

Varicella Vaccine – 1 dose given on or after the 1st birthday

Hepatitis B Vaccine – 3 doses

Students entering 2nd-5th Grade

DTaP Vaccine – 3 doses (Child age 7 or older with no previous doses should receive 3 doses adult type Td)

Polio Vaccine – Any 3 doses

Measles Vaccine – 2 doses (at least 1 month apart) **OR** documented immunity

Mumps & Rubella Vaccine – 1 dose given on or after the 1st birthday

Varicella Vaccine – 1 dose given on or after the 1st birthday

Hepatitis B Vaccine – 3 doses

Students entering 6th Grade or Higher

Same as above **PLUS**

Tdap- 1 dose given on or after 10th birthday or 5 years from the last DTP/DTaP or Td dose.

Meningococcal Vaccine – 1 dose

***In addition to immunization records, all new students must submit a report of a recent (less than 1 yr. old) physical examination.**

***Bloodwork for serologic evidence of immunity (antibody titer testing) is acceptable in lieu of receiving the 2nd dose of measles-containing vaccine.**

Students born or living outside the U.S. may need tuberculosis testing. http://www.nj.gov/health/tb/documents/school_mandate.pdf

HEALTH QUESTIONNAIRE
PARAMUS PUBLIC SCHOOLS

PARENTS/GUARDIANS: PLEASE COMPLETE **BOTH SIDES** OF THIS HEALTH FORM

Child's Name:_____ Birth Date:_____Sex: _____

Parents/Guardians:_____Siblings:

School:_____Grade:_____

Age: / / /
Sex: / / /

No.	Question	Y	N	Number & Explain All "YES" Answers
1.	Were there any problems during pregnancy and/or birth?			
2.	Do you have any concerns about your child's health (eating, sleeping, teeth, weight, skin, etc.)?			
3.	Has your child ever had any eye problems (difficulty seeing, crossed eyes, squinting, frequently red, watery)?			
4.	Has your child ever had an eye exam? Date: _____ Result:			
5.	Does your child wear glasses? All day?			
6.	Has your child ever had any ear or hearing problems (frequent earaches, difficulty hearing, tubes in ears)?			
7.	Has your child ever had a hearing test? Date: _____ Has your child ever had a hearing evaluation? Date: _____ Results:			
8.	Does your child wear hearing aids?			
9.	Did your child have any delays in motor skills?			
10.	Does your child have any speech problems (difficult to understand, stuttering, slow speech development)?			
11.	Has your child ever had speech therapy? Date:			
12.	Does your child have any other physical problem or impairment which might affect normal academic progress or participation in the usual school program?			
13.	Should there be any restriction of physical activity in school? Include nature and duration of restriction.			
14.	Does your child have any psychological, emotional or behavioral problems that might affect school performance?			
15.	Has your child had any accidents or illnesses serious enough to require hospitalization?			
16.	Has your child had any broken bones?			
17.	Is your child on any daily or long term medication?			
18.	Does your child have any health problem that might require emergency action while he/she is at school (seizures, insect sting allergy, bleeding problem, diabetes, severe asthma, etc.)?			
19.	Is there a family history of chronic illness or learning problems?			

HEALTH HISTORY FORM
PARAMUS PUBLIC SCHOOLS

PARENTS/GUARDIANS: PLEASE COMPLETE **BOTH SIDES** OF THIS HEALTH FORM

Child's Name:_____Grade:_____

Condition	Y	N	Date	Explanation
Asthma				
Allergic to Drugs				
Allergies – food, environment				
Chicken Pox				
Seizure Disorder				
Diabetes				
Ear Infections				
Hearing Problems				
Emotional Problems				
Heart Disease				
Hepatitis				
Kidney Disease				
Mononucleosis				
Nosebleeds				
Pneumonia				
Scarlet Fever				
Strep Infection				
Speech Difficulties				
Concussions				
Fractures				
Operations				
Severe Injuries				
Other Hospitalizations				
Other Conditions				
Other Injuries				

Is your child currently taking medication? _____ Name of Medication(s):_____

If yes, for what condition(s): _____

I give my permission for the school nurse to share all health information with the faculty as needed.

Signature of Parent/Guardian: _____ Date: _____

Nurse's Summary: _____

_____