



Teresa M Rafferty
Superintendent of Schools
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5205 Ludlow Street
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NOTICE REGARDING PHYSICAL EXAMINATION

Dear Parent/Guardian:

Physical examinations are an important way to keep students healthy and able to learn. The New Jersey State Board of Education and the New Jersey Department of Health and Senior Services recommend that every child have at least one physical examination during each developmental stage (early childhood, pre-adolescence and adolescence).

In keeping with this recommendation, the Piscataway School District requests that students in grades 3, 8 and 11 have a physical examination at their medical home, with their own healthcare provider. Your child's healthcare provider will provide a thorough examination, and can administer immunizations if any are needed.

Please complete the Health History/Record Update and have the Physical Examination form completed by your Healthcare Provider and return **both** to the Schor Health Office.

Any questions or concerns can be directed to Jasmine Cromartie, RN at 732-752-4457 X 5218.

Sincerely,

Jasmine Cromartie, RN, CSN

Health Services



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PHYSICAL EXAMINATION FORM

Pupil's Name _____ Birthdate _____

School _____ Grade _____

Immunizations DTP _____ DT _____ Td _____ Tdap _____

Polio _____ Meningococcal _____

MMR _____ MMR _____ Hep B _____ Heb B _____ Hep B _____

Varicella _____ HIB _____ PCV _____

Pneumococcal Conjugate _____ Influenza _____

Mantoux Tuberculin Skin Test: Date Administered _____ Date Read _____ Results _____ mm

Last Lead Test _____ Lead Test Results _____

Height _____ Weight _____ Blood Pressure _____ Hearing _____ Vision _____

Nutrition _____ Skin _____ Head _____ Eyes _____ Ears _____ Nose _____

Oral (Teeth/Gums) _____ Throat _____ Neck _____ Heart _____ Lungs _____

Abdomen/Hernia _____ Genitalia _____ Extremeties _____ Orthopedic _____

Scoliosis _____ Remarks _____ Neurological _____ CBC _____ Urinalysis _____

History of Illness/Injury _____

Medication _____

Participation in Physical Education/Sports/Activities _____

Remarks/Impressions/Summary _____

Physician's Signature _____

Date of Exam _____

Physician's Stamp

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Health History/Record Update

Pupil's Name _____
Last First Middle Grade (as of September)

Address _____ Date of Birth _____ Sex _____

Father's Name _____ Home Telephone _____ Cell # _____

Mother's Name _____ Home Telephone _____ Cell # _____

Guardian _____ Home Telephone _____ Cell # _____

The information provided in this update takes the place of any previous information. Health information will be shared with essential staff to assist in your child achieving educational goals.

HEALTH HISTORY	DATE	HEALTH HISTORY	DATE	HEALTH HISTORY	DATE
Allergy - Specify	Y N	Eczema	Y N	Injuries/Broken Bones/Stitches (List)	
		Eyeglasses/Contacts	Y N		
		Hearing Aid	Y N		
		Hearing Difficulties	Y N		
		Heart Disease	Y N		
Asthma	Y N	Hepatitis	Y N		
Autism Spectrum Disorder	Y N	Hematological Disorder	Y N	Operations (List)	
Auto Immune Disorders	Y N	Juvenile Rheumatoid Arthritis	Y N		
Chronic Otitis Media (Ear Infection)	Y N	Lyme Disease	Y N		
Congenital Disorder	Y N	Mononucleosis	Y N		
Convulsive Disorder	Y N	Neuromuscular Disorder	Y N	Hospitalizations (List)	
Diabetes	Y N	Strep Infections	Y N		
Drug Allergies - Specify	Y N	Other Illnesses - Specify	Y N		

MEDICAL RESTRICTIONS (Attach Physician's Note)

CURRENT MEDICATIONS (Prescriptions, Inhaler, EpiPen, etc.)

List all Children in Family (Oldest to Youngest)

Last Name/First Name	Birthdate	Last Name/First Name	Birthdate

Signature of Parent/Guardian _____ Date _____

Any additional information can be attached to this form.