PISCATAWAY
TOWNSHIP SCHOOLS

Teresa M Rafferty
Superintendent of Schools
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100 Behmer Road
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Fax 732 844-9407
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NOTICE REGARDING PHYSICAL EXAMINATION

Dear Parent/Guardian:

New Jersey State law requires a medical examination for students **upon entry into a school district**. In addition, the New Jersey State Board of Education and the New Jersey Department of Health and Senior Services emphasize the importance of subsequent examinations during each of the student's developmental stages. **Kindergarten Students** are required to have a physical exam. New students must have documentation of an entry exam. If your child had a recent physical examination, contact the nurse at your child's school to determine if it will meet the requirements. Physicals must be done by a medical provider (MD, DO, PA, or AP) who is licensed to practice in the United States. For September admission, physicals done on or after September 1, 2016 will be accepted.

The primary responsibility for the total health needs of the school child rests with the family and the child's own healthcare provider. A physical examination by a private provider allows for a more thorough and individual approach. It also provides the opportunity for additional immunizations if needed.

Please have the physical examination form completed by your healthcare provider and return the form to the Health Office by

SEPTEMBER 2017

Healthcare providers must be licensed in the United States.
Any questions or concerns can be directed to the nurse at your child's school.

Sincerely,

Deborah Dawson

Supervisor of Counseling and Health Services

5/17

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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/FirstName	Birthdate

Signature of Parent/Guardian_____ Date_____

Any additional information can be attached to this form.

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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