Clark Public Schools
Clark, New Jersey

Student Health Examination: To be completed by Physician.

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

Address_____ **Phone ( )** _____

School _____ **Sex: Male**___ **Female** ___

Date of Examination_____ **Weight** _____ **Height**_____ **B/P**_____

Check each line	Normal	Abnormal	Needs Follow-up	Not Examined
Ears				
Eyes				
Lymph Glands				
Thyroid				
Nose				
Throat				
Teeth-Mouth				
Heart				
Lungs				
Abdomen				
Hernia				
Genital-Urinary				
Orthopedic				
Scoliosis				
Skin				
Nutrition				
Nervous System				
Speech				
General Appearance				

Does student have any health conditions requiring treatment? ___No ___ Yes
Specify: _____

Does student have any allergies? ___No ___ Yes Please list: Foods: _____

Medication Allergies: _____

Other: _____

Is student currently taking any Medication? Yes___ No___ If Yes, please list medications and reason for medication. _____

_____ _____
Physician (print or stamp) Physician Signature

FY-09

STATE OF NEW JERSEY
HEALTH HISTORY AND APPRAISAL

IMMUNIZATION REGISTRY NUMBER

Name of Child (Last, First, M.I.) | Date of Birth (Mo/Day/Yr) | Sex ☐ Male ☐ Female

PARENT OR GUARDIAN — NAME | TELEPHONE NO.

ADDRESS

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination * (If Td or DT, indicate in corner box)					
Tdap					
POLIO – INACTIVATED POLIO VACCINE (IPV) If oral vaccine, indicate (OPV) in corner box					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB)**					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE **					
MENINGOCOCCAL					
HEPATITIS A ***					
HPV (HUMAN PAPILLOMAVIRUS) ***					
OTHER					

LEAD SCREENING	
Test Date	Result

Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	Date	Titer
Varicella	Date	Titer
Measles	Date	Titer
Mumps	Date	Titer
Rubella	Date	Titer

☐ Provisional admission attached–Date Granted: _____ ☐ Medical exemption attached ☐ Religious exemption attached

HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR
ALLERGIES		DRUG ALLERGIES		NEUROMUSC. DISORDER		AUTISM SPECTRUM DISORDERS	
ASTHMA		HEART DISEASE		CHRONIC OTITIS MEDIA		HEMATOLOGICAL DISORDERS	
CONGENITAL DISORDER		HEPATITIS		AUTO IMMUNE DISORDERS		OPERATIONS OR INJURIES	
CONVULSIVE DISORDER		LYME DISEASE		STREP INFECTIONS			
DIABETES		MONONUCLEOSIS		JUVENILE RHEUMATOID ARTHRITIS			

TB Screening (Mantoux Test)	Date	Date	Chest X-Ray	Date	Result Normal	Abnormal
Tested						
Read						
Result (MM)						

Medication
Reactor No Rx ☐
Date Started _____
Date Completed _____

VISION						
With correction	R					
	L					
	BOTH					
Without correction	R					
	L					
	BOTH					
Muscle Balance						

Color Perception — Date — Results

HEARING						
Date						
Sweep Check	R					
	L					

Please note: State law will not permit any child to be admitted to a public school unless immunizations have been completed and documented by an M.D., D.O., or Nurse Practitioner, specifically indicating a day, month and year administered.