Wayne Township Public Schools

Physical Examination Form

DATE OF EXAM _____

SCHOOL: _____ NURSE'S TELEPHONE #: _____

DATE GIVEN:_____ DUE BACK: _____ DATE RETURNED: _____

STUDENT'S NAME: _____ **D.O.B**.: _____ SEX: M F X GRADE: _____

****

Significant Medical / Surgical History: _____

Vision (Without glasses): (R) 20/_____ (L) 20/_____ (With correction): (R) 20/_____ (L) 20/_____ Hearing: (R) _____ (L) _____

Height _____ - _____% Weight _____ -_____% BMI _____ B/P _____/_____ Pulse _____

Allergies **Y** / **N** type: _____ ....Need for medication in school * **Y** / **N**

Asthma **Y / N** Classification: ❒ Intermittent ❒ Mild ❒ Moderate ❒ Severe ....Need for medication in school * **Y / N**

	WNL	Abnormal Findings		WNL	Abnormal Findings		WNL	Abnormal Findings
Ears (otoscopic)			Heart			Orthopedic		
Eyes			Lungs			Structural		
Lymph Glands			Abdomen			Posture		
Thyroid			Hernia			Feet		
Nose			Genito-Urinary			Speech		
Throat			Skin			General Appearance		
Teeth/ Mouth			Nervous System			Other:		

Scoliosis **Y** / **N** If yes: ❒ Mild ❒ Moderate ❒ Severe Date of last X-ray _____

WHAT (IF ANY) MODIFICATIONS ARE REQUIRED FOR FULL PARTICIPATION IN THE SCHOOL PROGRAM?

_____

IS THE CHILD RECEIVING MEDICATION? Y / N Type: _____ Need to be taken in school? * **Y / N**

IS THE CHILD RECEIVING ANY OTHER THERAPY? Y / N Type: _____

IF SO, WHAT ARE THE POSSIBLE EFFECTS? _____

REFERRALS MADE AS A RESULT OF THIS EXAMINATION: _____

* If answered yes (**Y**), complete the appropriate forms. Please consider scheduling non-emergency medication administration during non-school hours.

PHYSICIAN'S SIGNATURE _____ TELEPHONE _____

PRINTED NAME _____ FAX NUMBER _____

Physician's Stamp with Address

Follow-up appointment date: _____

IMMUNIZATIONS (Please indicate any immunizations administered during this visit.) ❒ Full record of immunizations required (if checked)

Td/DTap/DTP	**Tdap**	**Polio**	**MMR**	**Hib**	**Hep B**	**VZV**
1. _____	**1.** _____	**1.** _____	**1.** _____	**1.** _____	**1.** _____	**1.** _____
2. _____		**2.** _____	**2.** _____	**2.** _____	**2.** _____	**2.** _____
3. _____		**3.** _____	**(3.** _____**)**	**3.** _____	**3.** _____	
4. _____		**4.** _____		**4.** _____	**(4.**_____**)**	
5. _____				**5.** _____		

PCV-13	**MCV4**	**Hep A**	**HPV**	**Men B**	**Flu**	**Other**
1. _____	**1.** _____	**1.** _____	**1.** _____	**1.** _____	1. _____	_____
2. _____	**2.** _____	**2.** _____	**2.** _____	**2.** _____		_____
3. _____			**3.** _____			
4. _____						

PPD Mantoux Test: Planted _____ Read _____ Result _____mm IGRA Date: _____ Result _____

CXR Date: _____ Result _____ INH: Y / N _____mg x _____mos. Date started: _____ Date Completed:_____

Blood Lead Level _____mcg/dL Date Tested: _____ Not Available _____ Referred for Testing _____