Wayne
Township Public Schools

Department of Student Support Services

Please complete and **return this form to**: Suzanne Koransky, R.N., M.A., Supervisor of Health Services, Wayne Township Public Schools, 50 Nellis Drive, Wayne, New Jersey 07470

MEDICAL INFORMATION PERTAINING TO CHILD STUDY

The Child Study Team is undertaking a complete evaluation of the following student:

Name: _____ Grade: _____ Date of Birth: _____

Address: _____ Phone: _____ School: _____

Referral Reason: _____

CST Member: _____ Dated: _____

Please note any health concerns observed by the School Nurse: _____

_____

Height _____ Weight _____ lbs. _____ Head Circumference _____ inches **(if indicated)**

Blood Pressure _____/_____ General Appearance_____

Pulse _____

Vision (**specify test**)_____

Hearing (**specify method**)_____

Review of Systems/Physical Examination: **N** = Normal **X** = Defect **Cross out items not performed**

		Comments			Comments
	Hair & Scalp			Abdomen-Appearance	
	Skin			Abdomen-Masses	
	Eyes-Fundoscopic			Genito-Urinary	
	Eyes-Oculomotor			Menses (if applicable)	
	Eyes-other			Endocrine	
	Ears-Tympanic Membranes			Lymph Nodes	
	Ears-Canals			Extremities Joints	
	Ears-Other			Extremities-Muscles	
	Nasopharynx			Extremities-other	
	Oropharynx			Vertebral Column	
	Mouth-Teeth, Gums			Cranial Nerves	
	Mouth-other			Reflex intensity	
	Neck-Palpations			Reflex Symmetry	
	Chest-Appearance			Pathological Reflexes	
	Lung-Auscultation			Gait	
	Heart-Rhythm, Rate			Other items/tests	
	Heart-Murmurs				

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REMINDER: *No written, or other reference to, or disclosure of, HIV/AIDS information can made, unless specific written consent has been obtained.*

Please mark if YES, NO or NONE and explain.

	Yes	No	None	Explain/Restrictions *(if any)*
Allergies that might affect school behavior or attendance?				
Any medical factors with respect to health, safety, or participation in physical Education?				
Please list type and date of any recent immunizations.				
Has this child received in the past any Psychiatric or Neurological workup?				
Is this child receiving any medication or other therapy?				
Does the parent have any concerns that this child may suffer an Emotional Disorder?				
Has this child ever been seen for hearing or visual evaluations other than school screening?				
Does this child complain of recurring headaches, stomach aches, etc.?				
Is there any family history that may be significant for this child?				
In your judgment, does this student need additional medical or psychiatric workup or treatment, besides the routine child Study Team Psychological evaluation?				

Summary Statement on findings and overall Health/Effect on child's learning:_____

_____

_____

If there are factors you prefer to discuss, please call 973-633-3000, and ask for the Child Study Team Case Manager, _____.

Thank you for your cooperation.

Signature of Examining Physician _____ Dated: _____

Reviewed by School Physician _____ Dated: _____