WEST ORANGE PUBLIC SCHOOLS

179 Eagle Rock Avenue **West Orange, New Jersey 07052**
Department of Student Support Services (973) 669-5400 ext. 20538 Fax: (973) 669-8601

PUPIL HEALTH EXAMINATION

Name _____ Gender _____ Date of Birth _____
(Last) (First)

School of Attendance _____ Grade: _____

HEALTH HISTORY

Pertinent Medical History _____

Allergies _____

Type of Reaction: _____ Treatment/Medication: _____

Is this child on medication? _____ Yes _____ No Type of Medication & Reason: _____

Latest Immunization (Dates): Hep. B #1 _____ #2 _____ #3 _____ DTP _____ DT _____

OPV/IPV _____ MMR _____ Varivax _____ Pneumococcal _____ Hepatitis A _____

Meningococcal Vaccine _____ Influenza Vaccine _____ Other _____

Mantoux Tuberculin Test Date _____ Neg _____ Pos _____ _____ mm induration

If positive, result of X-ray _____ Treatment _____

PHYSICAL EXAMINATION

Height _____ Weight _____ Blood Pressure _____

Head _____ Heart Rate _____ Murmurs _____

Ears _____ Hearing R _____ L _____ Lungs _____

Face _____ Abdomen _____

Eyes _____ Vision R _____ L _____ Both _____

Nose _____ Corrected - Glasses / Contacts _____

Mouth _____ Extremities/Orthopedic _____

Teeth _____ Central Nervous System _____

Throat _____ Genitalia _____

Neck _____ Scoliosis Screening Neg. _____ Pos. _____

Scalp _____ If positive, x-ray _____

Skin _____ Treatment _____

SUMMARY: _____

RECOMMENDATION: Student may participate in all physical activities Yes _____ No _____

Student may not participate in the following physical activities: _____

Laboratory work (if indicated) _____ Urinalysis _____ Blood work-up _____

Other Medical Recommendations: _____

Signature _____ Date of physical _____

Examiner Name and Title _____ Check one _____ School Physician

Address _____ _____ Private Physician

Telephone _____ _____ Advanced Practice Nurse