

MEDFORD TOWNSHIP PUBLIC SCHOOLS HISTORY AND PHYSICAL FORM

Last Name

First Name

Date of Birth

Sex

HISTORY

PLEASE INDICATE DATESFORM MUST BE COMPLETED BY DOCTOR'S OFFICE***

Prenatal/Neonatal Problems: _____

Allergies or Drug Reactions: _____

Recurring Strep Infections: _____ Speech Concerns: _____

Bed Wetting or Encopresis: _____ Sleep Disturbances: _____

Heart Murmur: _____ Any Limitations: _____

Congenital Anomalies: _____

Surgical Procedures: _____

Asthma/RAD: _____ Medications: _____

Chronic Otitis Media: _____ Chicken Pox: _____ Lyme Disease: _____

Seizure Disorder: _____ Type: _____ Medication: _____

Diabetes: _____ Neuromuscular Disorder: _____ Mononucleosis: _____

Obsessive-Compulsive Behaviors: _____

ADHD or ADD (note medication): _____

Broken Bones or Injuries: _____

Other Problems: _____

PHYSICAL EXAMINATION

Height

Weight

BP

Vision Test

Hearing Test

ENT: _____ Lymph Glands: _____ Thyroid: _____

Teeth: _____ Heart: _____ Lungs: _____

Abdomen: _____ Hernia: _____ Genito-Urinary: _____

Orthopedic: _____ Scoliosis: _____ Skin: _____

Nutrition: _____ Nervous System: _____

Abnormalities: _____

OVER →

IMMUNIZATIONS REQUIRED BY THE NEW JERSEY DEPARTMENT OF HEALTH

Vaccine (Indicate Type)	1 st Dose Mo/Day/Yr	2 nd Dose Mo/Day/Yr	3 rd Dose Mo/Day/Yr	4 th Dose Mo/Day/Yr	5 th Dose Mo/Day/Yr
DPT, DT or DtaP	/ /	/ /	/ /	/ /	/ /
OPV or IPV	/ /	/ /	/ /	/ /	/ /
HIB	/ /	/ /	/ /	/ /	/ /
Hepatitis B	/ /	/ /	/ /		
MMR	/ /	/ /			
Varivax	/ /				

Required Immunizations:

DPT, DT or DtaP: four with one dose given after the 4th birthday or any 5 doses
OPV: three with one dose given after the 4th birthday or any 4 dose
MMR: two with the first dose given after the 1st birthday
Hepatitis B: series of three given over a six month interval
HIB: required for preschool program

Tuberculosis testing: _____
Date Results

Does this child have any physical needs or restrictions that would prevent him from participating in any school activities including gym and sports?

No Yes Please explain: _____

Does this child receive any medication at home or school? No Yes : _____

Does this child have any serious food allergies or serious reactions to stinging insects (bees, wasps, yellow jacket)? No Yes : _____

Has your child ever received early intervention or special education services? No Yes

**Office Stamp
or Printed Name:**

**Doctor's or Nurse
Practitioner's Signature** Date