PRE-SCHOOL PHYSICAL EXAMINATION AND IMMUNIZATION RECORD

Name _____ Date of Birth _____

Physical examination record

Height_____ Weight_____

Blood pressure_____ Pulse_____

Vision (r)_____(l)_____ Hearing (r)_____(l)_____

Eyes_____ Lungs_____

Ears, Nose, Throat_____ Abdomen_____

Mouth and teeth_____ Skin_____

Neck_____ Genitals/Hernia_____

Heart_____ Extremities_____

Allergies_____ Restrictions from activities_____

Recommendations:_____

_____

Pre-school immunizations * *Required*

8 is *recommended* for pre-school entrance (will be required for **kindergarten**).

Type of Vaccine	Dose 1	Dose 2	Dose 3	Boosters
1 DPT/DTaP	*	*	*	*
2 POLIO	*	*	*	
3 MMR	*			
4 VARICELLA (chicken pox)	* one dose *or* disease			
5 HIB	*			
6 INFLUENZA (before Dec. 31st)	*			
7 PNEUMOCOCCAL 8 # Hepatitis B	*			

*Doctor's Name (PRINT)*_____

*Doctor's Address*_____ *Telephone*_____

*Doctor's Signature*_____ *Date of Exam*_____

_____

Student Health Inventory

Teacher_____ Grade_____ School_____

Your child's learning depends upon good health. To assist in providing health services at school, please complete the following and return this to the School Nurse.

Name_____ Birthdate_____ Boy ☐ Girl ☐
Last First Middle

Parent/Guardian_____ Phone #_____

Parent's employment _____ _____
Father Phone Mother Phone

Emergency Contacts _____ _____
(Other than parent) Name Phone Name Phone

Last School attended_____
Name City State

Doctor's name_____ Date of last physical _____

Dentist's name_____ Date of last exam_____

Is student under an orthodontist's care? Yes ☐ No ☐ Doctor's name_____

Does student have:

Allergies? Yes ☐ No ☐ To drugs, food, insects, pollen? Please list_____
Has the allergy required emergency action in the past? Yes ☐ No ☐
Comments_____

Bee sting allergy? Yes ☐ No ☐ Describe reaction _____
Difficult breathing? Yes ☐ No ☐ Need emergency medication? Yes ☐ No ☐

Asthma? Yes ☐ No ☐ Triggered by_____ Treatment_____
Diagnosed by doctor _____ Date_____

Diabetes? Yes ☐ No ☐ Takes insulin? Yes ☐ No ☐ Date Diagnosed_____
Epilepsy/Seizures Yes ☐ No ☐ Describe seizure _____
Date of last seizure _____ Medication_____
Is student currently under a doctor's care for seizures? Yes ☐ No ☐

Heart condition? Yes ☐ No ☐ Describe _____
Any physical restrictions? _____Medication? Yes ☐ No ☐

Bone or joint problems? Yes ☐ No ☐ Describe _____
Any physical restrictions? _____

Check off the following regarding health concerns that pertain to student:

Eyes: ☐ Glasses ☐ Reading ☐ Distance ☐ Contacts ☐ Crossed ☐ Difficulty seeing ☐ Lazy Eye

Ears: ☐ Frequent Infections ☐ Tubes ☐ Hearing difficulty, explain

Hearing Aid ☐ Right ☐ Left ☐ Wear at School ☐ Other

Other: ☐ nosebleeds ☐ lungs ☐ eating ☐ neurologic ☐ sleeping ☐ headaches ☐ bladder ☐ bowel ☐ skin ☐ dental ☐ phobias ☐ ADD/ADHD ☐ bedwetting

Daily medication at home? Yes ☐ No ☐ At school? Yes ☐ No ☐ Emergency only? Yes ☐ No ☐
Name of medication and reason for taking_____
List serious illness or injuries_____
Surgeries (*operations*)_____ Condition that prevents PE participation_____
Other health information or concerns_____

If student requires medication at school, or a change in PE participation, please obtain the appropriate form in the school office.

The Camden County School Nurse program for non-public schools is administered by the Southern NJ Perinatal Cooperative.