TOMS RIVER REGIONAL SCHOOLS

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NEW STUDENT PHYSICAL EXAMINATION
Report of Private Physician/Advanced Practice Nurse

STUDENT: _____ DATE OF BIRTH: _____

GRADE/CLASS: _____ SCHOOL: _____ DATE OF ENTRY: _____

ALLERGIES: _____

HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____

EYES: _____ TEETH/MOUTH: _____ ORTHOPEDIC –

VISION: (R) _____ THYROID: _____ SCOLIOSIS: _____

(L) _____ LYMPH GLANDS: _____ STRUCTURAL: _____

CORRECTED: _____ HEART: _____ POSTURE: _____

EARS: _____ LUNGS: _____ FEET: _____

HEARING: _____ ABDOMEN: _____ NERVOUS SYSTEM: _____

NOSE: _____ GENITO-URINARY: _____ NUTRITION: _____

THROAT: _____ SPEECH: _____ OTHER: _____

COMMENTS: _____

_____

MANTOUX: within the last 6 months ____ required ____ not required _____ _____
Date Date

PLEASE PROVIDE EXACT DATES OF IMMUNIZATIONS:

DPT: _____ _____ _____ _____ _____
(DtaP)
Tdap: _____

POLIO: _____ _____ _____ _____
(OPV or IPV)
MMR: _____ _____

HEPATITIS B: _____ _____ _____

MENINGOCOCCAL: _____

VARICELLA VACCINE: _____ **OR DISEASE DATE:** _____

I have examined this child and find him/her physically fit to participate in all school activities.

_____ _____
SIGNATURE OF PHYSICIAN/APN **Date of Examination**
(NO STAMPS OR COUNTER-SIGNATURES)

_____ _____
NAME OF PHYSICIAN/APN (please print) DATE **STAMP**

THIS FORM MUST BE COMPLETED AND RETURNED TO THE SCHOOL NURSE **REVISED 1/31/2017**