SPARTA TOWNSHIP SCHOOLS
PHYSICAL EXAMINATION FORM

Please fill out form completely Date of Exam: _____

Name:_____ DOB_____ Grade_____

Height_____Weight_____Blood Pressure_____Pulse_____

HEALTH HISTORY: State, date and describe in comments:
Allergies: insects, food, environmental:_____

Asthma:_____	Hepatitis_____	Pneumonia_____
Chicken Pox_____	Lyme Disease_____	Seizures_____
Diabetes_____	Mononucleosis_____	Skin Problems_____
Drug Sensitivities_____	Neuromuscular_____	Strep_____
Heart Disease_____	Nosebleeds_____	Headaches_____
Otitis Media_____	Other_____	

Comments_____

History of recent illness, injury or surgery:_____

Is this child currently receiving any medication or therapy? Yes _____No_____
If yes, please indicate type, dose, reason and duration:_____
_____

Please indicate any educational or physical restrictions in the student's programs or activities:
_____.

PHYSICAL EXAM: Please describe any physical problems found:_____
_____

RESULTS OF SCOLIOSIS EXAM; _____

VISION SCREENING: OD_____OS_____OU_____ Corrected: Yes No

IMMUNIZATION UPDATE: Enter complete date, as required by State of NJ or attach copy of updated immunization record.

Tdap Booster:		Month_____	Day_____	Year_____
Meningococcal:		Month_____	Day_____	Year_____
Hepatitis A:	#1	Month_____	Day_____	Year_____
	#2	Month_____	Day_____	Year_____
Varicella Booster:		Month_____	Day_____	Year_____
HPV:	#1	Month_____	Day_____	Year_____
	#2	Month_____	Day_____	Year_____
	#3	Month_____	Day_____	Year_____
Other:		Month_____	Day_____	Year_____

HEALTHCARE PROVIDER SIGNATURE_____
HEALTHCARE PROVIDER PRINTED NAME:_____
DATE:_____
HEALTHCARE PROVIDER STAMP: