

Rumson School District
Health Examination Form

Student's Name: _____ Date of Birth: _____

School: _____ Age: _____ Grade: _____

Significant Past Illness or Injury: _____

Varicella Disease: _____

Allergies: _____

Vaccine type	Disease Date	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	Other Mo/Day/Yr
Diphtheria, tetanus, pertussis –DTP (If DT or Td, indicate in corner box)							
Polio Oral Polio Vaccine (OPV) If Salk, indicate IPV in corner box.							
Measles, mumps, rubella (MMR)							
Measles					Measles Serology	Date:	Titer:
Rubella					Rubella Serology	Date:	Titer:
Mumps					Mumps Serology	Date:	Titer:
Haemophilus B (HIB)							
Hepatitis B							
Varicella							
Other (Specify)							

Examination:

Height: _____ Weight: _____ BP _____

Eyes: _____ Vision Tested: Yes ___ No ___ Wears Glasses _____

Ears: _____ Hearing Testing: Yes ___ No ___

Respiratory _____ Cardiovascular _____

Liver _____ Spleen _____ Hernia _____

Musculo-Skeletal _____ Skin _____

Scoliosis Screening _____ Genitalia _____

Neurological _____ Urinalysis performed: Yes ___ No ___

Presently taking medication? Yes ___ No ___ If yes, will this be taken during school? _____

If yes, please specify _____

Restrictions in Physical Education? Yes ___ No ___ Comments: _____

Mantoux TB Test given? Yes ___ No ___ Date _____ Results _____

Signature of Examining Physician: _____ Date _____

Physician's Address: _____ Phone _____