WARREN TOWNSHIP SCHOOL
PHYSICAL EXAMINATION FORM- ELEMENTARY

COMPLETED BY PARENT	Student Name (Last, First, MI)	Date of Birth	Gender M F
	Parent/Guardian	Phone (With Area Code)	
	Address		

COMPLETED BY PHYSICIAN:

Physical Examination: Each area of the examination form MUST BE COMPLETED with examination results. Checks are NOT adequate documentation of results.

Height:	Weight:	Blood Pressure:	Allergies?	Taking Medications?
Has Student had Eye Exam? Yes No Glasses? Yes No Contacts? Yes No	Visual Acuity R 20/ L20/ With Correction? Yes No	Audiogram Results:	Please List:	Please List:

Abdomen:		Eyes:	Skin:
		Ears:	Head:
Chest Contour:		Nose:	
			Throat:
Lungs:	Heart: Rate & Rhythm	Neck:	
		Lymph Glands:	Teeth:
Genito-Urinary: Hernia? Yes No		Thyroid Range of Motion:	Mouth:
		Spine: Range of Motion:	Extremities:
Neurological: (Balance-Coordination-Abnormal Reflexes)		Curvature of Spine:	

Additional Comments:_____

Other Special Problems:_____

Approved for Sports:___

Rejected for Sports:____ **Reason:**_____

Date of Examination:_____ **Physician Signature:**_____
(Completed within 365 days prior to entry into school and submitted on entry.)

(Must be licensed in the State of New Jersey.)
Physician Stamp and License Number:

3/04PK

SCHOOL IMMUNIZATION RECORD (Required upon Enrollment)
Form for Students Born On or After 1/1/90
****New Students: Please provide Complete Record **All Others: Please provide Updates Only**

Name of Child (Last, First, MI)	Birth Date (Mo/Day/Yr)	Sex ☐ Male ☐ Female

Parent or Guardian	**Name:** _____ **Phone**_____ **Address:**_____ _____

Vaccine Type	Required Doses	Disease	Series Dates (Month/Day/Year)REQUIRED 1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose	6TH gr. Booster Tdap/Td*
Diphtheria, Tetanus & Pertussis (DTP, DtaP and/or Td) Three (3) doses required for preschool students	**4** One required on or after 4th Birthday OR 5 or more doses total							
Polio (Indicate IPV or OPV)	**3** (One on or after 4th Birthday) OR 4 doses Total		☐	☐	☐	☐	☐	☐
MMR (On or after 1st Birthday, at least one (1) month apart or one(1)+ documentation of positive immune titer.	**2** preferred or							
Measles (Same as MMR)	2							
Rubella	1							
Mumps	1							
HIB Required for Preschool Students only	**1** Minimum							
HepB 3 doses required for Students entering Kindergarten or First Grade and all 6th Grade Students beginning Sept. 1, 2001	**3** M/D/Yr All Doses							
Varicella Vaccine on or after the first birthday (Lab confirmed immunity,.or MD or parent statement of disease)	**1**							
Meningococcal for Students born on or after Jan. 1,1997 enrolled in 6th grade	**1**							
Mantoux ** (Within 6 months)	**1**							
Pneumococcal (preschool only)	**1**							
Influenza (preschool only)given by December of each year.	**1**							

**Required for certain countries (New update each year from the State Board of Health)

* Children born on or after Jan. 1 1997 entering or attending Grade 6 beginning Sept. 2008 shall have received one dose of Tdap given no earlier than 10th birthday. If your child received a Td booster dose within 5 years of entering 6th grade, he/she is not required to receive a Tdap dose until 5 years have elapsed from last DTP/DTaP or Td dose.

PHYSICIANS SIGNATURE _____REQUIRED

3/08