FRENCHTOWN ELEMENTARY SCHOOL
Frenchtown, New Jersey
(To be completed by family physician)

PUPIL'S NAME _____ **DATE OF EXAMINATION** _____
Height _____ Weight _____ BP _____
Visual acuity _____ OD _____ OS _____

Head and Scalp	_____	Lungs	_____
Eyes	_____	Heart	_____
Ears	_____	Abdomen	_____
Nose	_____	Genitalia	_____
Throat	_____	Extremities	_____
Oral Hygiene	_____	Back	_____
Dentition	_____	Neurologic	_____
Thyroid	_____	Skin and Nails	_____
Glands	_____	Nutrition	_____

Lab Data (if deemed necessary)

HCT _____ U/A _____

Operations, deformities or defects: _____

Specific Recommendations: _____

IMMUNIZATION RECORD

Test for TB	**Date**	**Type**	**Result**

Vaccine Type	**1st Dose**	**2nd Dose**	**3rd Dose**	**4th Dose**	**5th Dose**
DPT/DTaP					
DT					
Td					
Tdap					
Polio					
Hib					
MMR					
Measles Vaccine					
Rubella Vaccine					
Mumps Vaccine					
Hepatitis B					
Varicella					
Pneumococcal					
Meningococcal					
Influenza					
Other, Specify					

_____ _____

Physician Signature Date

Frenchtown Elementary School District
Frenchtown, New Jersey 08825

PRESCHOOL/KINDERGARTEN HEALTH EXAMINATION RECORD
(to be completed by family physician)

PUPIL'S NAME _____ **DATE** _____

BIRTHDATE _____

A. History (continue answer on back of form, if necessary)

1. Is there any significant health problem of which the school health personnel should be aware?

2. Is there any past history of serious illness, injury or operation?

3. Is there any family history of significant inheritable disease?

B. Physical Examination Height _____ Weight _____ BP _____
Visual Acuity od _____ os _____

Check the following. If abnormal, indicate and explain in detail to the side or back of page.

Head	Heart
Eyes	Abdomen
Ears	Genitalia
Nose	Extremities
Mouth	Back
Dentition	Neurologic
Throat	Skin and nails
Thyroid	Nodes
Lungs	Nutrition

C. Lab data (if deemed necessary)
Hematocrit _____ Urinalysis _____ Mantoux _____

D. Immunizations (please insert dates)
DPT/DTaP 1._____2._____3._____4._____5._____
OPV 1._____2._____3._____4._____5._____
MMR 1._____2._____
HAEMOPHILUS B_____
HEPATITIS B _____
VARICELLA _____
PNEUMOCOCCAL _____
INFLUENZA _____
OTHER, SPECIFY _____

Print or stamp physician
name, address, phone number

_____
Physician's signature