SOUTH PLAINFIELD PUBLIC SCHOOLS
ENTRANCE PHYSICAL FORM

Last Name _____First Name _____MI_____

Address_____Home Phone _____

Date of Birth_____ Gender_____

Parent/Guardian _____

Cell Phone_____Work Phone_____

Height_____Weight_____Speech_____Nutrition _____

Nose_____Throat_____Teeth/Mouth_____Ears _____

Heart_____Lungs_____Skin_____Eyes _____

BP _____

Orthopedic: Neck/Back/Spine_____Scoliosis_____Feet _____

Nervous System_____Thyroid_____Abdomen _____

Genitals_____Hernia _____

Vision: R_____L _____ Corrected/Uncorrected (circle one)

Hearing: R_____L _____

Disease History	Year	Disease History	Year	Disease History	Year
Allergies:		Heart Disease:		Auto Immune Disorders:	
Asthma:		Hepatitis:		Strep Infections:	
Congenital Disorder:		Lyme Disease:		Juvenile Rheumatoid Arthritis:	
Seizure Disorder:		Mononucleosis:		Autism Spectrum Disorders:	
Diabetes:		Neuromuscular Disorder:		Hematological Disorders:	
Drug Allergies:		Chronic Otitis Media:		Other:	
Operations: **Date:**					
General Medical Conditions:					

OVER

Last Name _____First Name _____MI_____

Record of REQUIRED immunizations as per N.J.A.C. 8:57-4 Immunization of Pupils in School

VACCINE TYPE	1st Dose Mo/Day/ Yr	2nd Dose Mo/Day/ Yr	3rd Dose Mo/Day/ Yr	4th Dose Mo/Day/ Yr	5th Dose Mo/Day/ Yr	LEAD SCREENING	
Diphtheria, Tetanus, Pertussis (DTap) or any combination. (If Td or DT indicate in appropriate box)						TEST DATE:	RESULTS:
Tdap.							
Polio-Inactivated Polio Vaccine (IPV) If oral vaccine indicate (OPV)							
Measles, Mumps, Rubella (MMR)					**Document below single antigen vaccine receipt, serology titers, or Varicella disease history**		
Haemophilus B (HIB)							
Hepatitis B					Hepatitis B	Vaccine Date:	Titer Date:
Varicella							
Pneumococcal Conjugate					Measles	Vaccine Date:	Titer Date:
Meningococcal							
Hepatitis A					Mumps	Vaccine Date:	Titer Date:
Human Papillomavirus (HPV)					Rubella	Vaccine Date:	Titer Date:
Influenza							
Other					Varicella	Disease Date:	

MANTOUX	DATE:	RESULT:	CXR	DATE:	RESULT:	MEDICATION THERAPY

Mantoux may be required pursuant to N.J.S.A. 18A:40-16 through 19

_____Medical Exemption Attached _____Religious Exemption Attached

_____ _____

Physician's Name & Stamp Physician's Signature

Address_____ Date of Exam _____

_____ Phone_____