HOLMDEL TOWNSHIP PUBLIC SCHOOLS

Health Examination Form for New Students

Student's Name: _____

Address: _____

Date of Birth: _____ Age: _____

School: _____ Grade: _____

	Date	Date	Date	Date	Date
DTAP	_____	_____	_____	_____	_____
IPV/OPV	_____	_____	_____	_____	
Hepatitis A	_____	_____	_____		
Hepatitis B	_____	_____	_____		
Varivax	_____	_____	or disease date	_____	_____
MMR	_____	_____			
Measles	_____	Mumps	_____	Rubella	_____
Mantoux Test	Date given:_____		Date read: _____		Result (MM)_____

	Normal	Abnormal	Comments
Height _____	□	□	_____
Weight _____	□	□	_____
Eyes (i.e, Wears glasses?)	□	□	_____
Ears	□	□	_____
Respiratory	□	□	_____
Cardiovascular	□	□	_____
Blood Pressure _____	□	□	_____
Abdominal	□	□	_____
Musculo-Skeletal	□	□	_____
Skin	□	□	_____
Neurological	□	□	_____
Genitalia	□	□	_____

Other _____

_____

Presently taking medication? No □ Yes □

If yes, will this be taken during school? No □ Yes □

If yes, please provide a doctor's prescription/order to the school nurse as per attached form.

Restrict in Physical Education? No □ Yes □

Please explain _____

Examining Physician (type or print) _____

Physician's Signature _____ Date _____

Physician's Address _____ Telephone No. _____

Holmdel Township Public Schools
School Health Services Program

Authorization for medication to be taken during school hours or school sponsored activities

A. This section to be completed by the parent or guardian

Child's Name: _____
Last First
Date of Birth: _____ Gender: _____

Physician's Name: _____

Physician's Address: _____

Physician's Telephone Number: _____

_____ I request that my child be assisted in taking the medicine(s) described below at school, by legally authorized persons.

_____ I request that my child be permitted to self-administer the medicine(s), **for life-threatening illness***, both which are described below.

** Life-threatening illness means an illness or condition that requires an immediate response to specific symptoms or sequelae that if left untreated may lead to potential loss of life such as, but not limited to, the use an inhaler to treat an asthma attach or the use of an adrenalin injection to treat a potential anaphylactic reaction.*

Parent/Guardian's Name: _____
(Please print)
Parent/Guardian's Signature: _____

Home Telephone Number: _____ Emergency Telephone Number:_____

B. This section to be completed by the physician

Name of medicine(s)	
Form	
Dose	
If prescribed daily, what time?	
If prescribed "when needed," describe indications.	
How soon can the medication dose be repeated?	
List significant side effects.	
Is this medication for a life threatening illness?	
Is the child authorized to self-administer the medication	
Has the child been trained by the physician?	
Length of time this treatment is recommended?	
Other Information or concerns	

Physician's Signature: _____ Date:_____