



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 B	_____	_____	_____	_____	_____
Hepatitis A	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____
Varivax	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____
Measles	_____	_____	_____	_____	_____
Mantoux Test	Date given: _____	_____	Date read: _____	_____	Result (MM) _____
Meningitis	_____	_____	_____	_____	_____

or disease date _____

Mumps _____

Rubella _____

Other Vaccines _____

	Normal	Abnormal	Comments
Height _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes (i.e., Wears glasses?)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdominal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculo-Skeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	_____
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. _____