**Saint Michael School**

Physical Examination Form

**THIS IS A REQUIREMENT**

27 Crittenden Street

Newark, NJ 07104

Phone: 973-482-7400

Fax: 973-482-1833

Dear Parents/Guardians:

We require new students to have an up to date physical examination/wellness checkup. The child’s physical is to be completed no later than the first week of September so that it will be valid for the current academic school year and your child may begin school with the rest of his/her class. Please have your child’s doctor fill out this form, sign it, and date it.

Sincerely,

Rosemarie Pallino, RN

School Nurse

**PLEASE PRINT**

Child’s Last Name: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s First Name: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_

**IMMUNIZATION DATES**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| HBV | |  |  | |  | |  | |  | |
| DPT | |  |  | |  | |  | |
| POLIO | |  |  | |  | |  | | | | | | |
| Hib | |  |  | |  | |  | |
| Pneumococcal (PCV) | |  |  | |  | |  | |
| MMR | |  |  | |  | | | | | | | | |
| VARIVAX | |  |
| \*MENACTRA | |  | \*For those entering grade 6 | | | | |
| \*TDAP | |  | \*For those entering grade 6 | | | | |
| General Appearance | | | | | | | | | |
| Height |  | | | Weight | |  | | | | Overweight | |  |
| Eyes |  | | | Ears | |  | | | | Teeth | |  |  |
| Nose |  | | | Tonsils | |  | | | | Thyroid | |  |
| Mouth |  | | | Heart | |  | | | | Lungs | |  |
| Neck  (Lymph Nodes) |  | | | Hernia | |  | | | | Abdomen  Scars | |  |
| Blood Pressure |  | | | Pulse | |  | | | | Extremities | |  |
| Nervous System / Epilepsy: | | | | Allergies (Bee Sting, Peanuts): | | | | | | Significant Medical Conditions: | | | |
| Necessary Medications: | | | | May take Physical Education:  Yes \_\_\_\_\_\_ No \_\_\_\_\_\_ | | | | | | | | Remarks: | |

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHYSICIAN’S SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE PRINT NAME AND ADDRESS OR USE RUBBER STAMP:

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