Rumson School District
Health Examination Form

Student's Name _____ Date of Birth _____

School _____ Age _____ Grade _____

Significant or Past Illness or Injury: _____

Varicella Disease: _____

Allergies: _____

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	
						Test Date	Result
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination ** (If Td or DT, indicate in corner box)*							
Tdap							
POLIO – INACTIVATED POLIO VACCINE (IPV) *If oral vaccine, indicate (OPV) in corner box*							
MEASLES, MUMPS, RUBELLA (MMR)							
HAEMOPHILUS B (HIB)**							
HEPATITIS B							
VARICELLA							
PNEUMOCOCCAL CONJUGATE **							
MENINGOCOCCAL							
HEPATITIS A ***							
HPV (HUMAN PAPILLOMAVIRUS) ***							
OTHER							

Document below single antigen vaccine receipt, serology titers, or varicella disease history		
Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

Examination:

Height _____ Weight _____ BP _____

Eyes: _____ Vision Tested? Yes _____ No _____ Wears Glasses? _____

Ears: _____ Hearing Tested? Yes _____ No _____

Respiratory _____ Cardiovascular _____

Liver _____ Spleen _____ Hernia _____

Musculo-Skeletal _____ Skin _____

Scoliosis Screening _____ Genitalia _____

Neurological _____ Urinalysis performed: Yes _____ No _____

Presently taking medication? Yes _____ No _____ If yes, will this be taken during school? _____

If yes, please specify: _____

Restrictions in Physical Education? Yes _____ No _____ Comments _____

_____

Mantoux TB Test Given? Yes _____ No _____ Date _____ Results _____

Signature of Examining Physician _____ Date _____

Physician's Address _____ Phone _____