HEALTH SERVICES DEPARTMENT
BERGENFIELD PUBLIC SCHOOLS
SCHOOL EXAMINATION FORM
Grades: Pre-K through 5

NAME (last) ________ (first) ________ ADDRESS ________ DATE OF EXAM ________

BIRTH DATE ________ PARENT'S NAME ________ PHONE ________

PHYSICAL REPORT: Grade _____ Age ____

Ht _____ Wt _____ BP _____

Eyes _____ R 20/ _____ L 20/ _____ Ears __________ Hearing R __________ L __________

Respiratory ____

Cardiovascular ____

Abdomen ____________________ Genitalia ____________________

Musculoskeletal ____________________ Skin ____________________

Neurological ____

LABORATORY: Urinalysis __________ HGB/HT __________ Other __________

COMMENTS:

IMMUNIZATIONS

(Insert dates)

Complete for new students. Otherwise only those since last report.

DPT	DPT	DPT
DPT	Td	Td
Polio (OPV/IPV)	Polio (OPV/IPV)	Polio (OPV/IPV)
Polio (OPV/IPV)	Polio (OPV/IPV)	Polio (OPV/IPV)

MMR __________ __________

Varivax __________ __________

Hepatitis B	Hep B	Hep B
Hib	Hib	Hib

Flu __________ __________

PCV __________ __________

Mantoux __________ __________

Date Planted Date Read

__________ Results

RECOMMENDATIONS:	Yes	No
1. Any defect of vision, hearing or speech that the school could compensate for by proper seating, etc?	☐	☐
2. Any conditions limiting --Classroom activity? --Physical education?	☐	☐
3. Any significant allergies?	☐	☐
4. Any condition which may result in a classroom emergency	☐	☐
5. Any emotional, mental or physical condition requiring periodic medical observation?	☐	☐

COMMENTS:

STAMP:

Phone ____________________ Date: __________ ____________________ M.D.

Signature

Revised 2013