Attention: Please fill out both sides of this form and return to school in a timely manner.

VOORHEES TOWNSHIP PUBLIC SCHOOLS

Medical Examination Form

Student Name _____ DOB _____

Address _____

Parent/Guardian _____

To be completed by Family Physician prior to student's admittance to school.

I. Blood Pressure _____ Pulse _____ Hearing Test _____

Height _____ Weight _____

Vision (without glasses) _____ Vision (with glasses) _____

II.

Systems Examined	Comments About Findings
- General Appearance	
- Ears	
- Eyes	
- Lymph Glands	
- Thyroid	
- Nose	
- Throat	
- Teeth-Mouth	
- Heart	
- Lungs	
- Abdomen	
- Hernia	
- Genito-urinary	
- Orthopedic: Structural	
Posture	
Feet	
- Skin	
- Nutrition	
- Nervous System	
- Speech	

III. Behavioral Observations: _____

_____

IV. History Summary:

A. Abnormal conditions which may require education evaluation, environmental accommodations or limits on activities: _____

B. Serious or chronic illnesses treated by physician:

C. Operations and/or hospitalizations: _____

V. Allergies: (food, medicines, insect bites-stings, other) _____

_____

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

REQUIRES MEDICAL EXEMPTION **REQUIRED FOR DAY/CHILD CARE ENROLLEES (2 Months-5th Birthday Only) ***Not Required

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:

MANTOUX TEST	**DATE**	**Results / Data**
MEDICAL NOTES:		

Examining Physical (Print)

Telephone

Signature of Physician

Date