Dear Parent(s)/Guardian(s):

The rules of the NJ State Board of Education (NJAC 6A:16-2.2 & NJSA 18A:40-4) require that your child must be examined by a healthcare provider, and that a full report of the examination must be presented to the school. This examination must be done no more than 365 days prior to entry and must state what, if any, modifications are required for full participation in the school program.

Please return the attached form to the school nurse in your child's school prior to entry into school.

Thank you.

Sincerely,

School Nurses
Washington Township School District

☐ School Nurse
Flocktown-Kossmann School
90 Flocktown Rd.
Long Valley, NJ
07853
☐ Grades PreK-2 908-850-1010
Fax# 908-850-0452
☐ Grades 3-5 908-850-1010
Fax# 908-852-0437

☐ School Nurse
Old Farmers School
51 Old Farmers Rd.
Long Valley, NJ
07853
908-876-3865
Fax# 908-876-9506

☐ School Nurse
Cucinella School
470 Naughright Rd
Long Valley, NJ
07853
908-850-3161
Fax# 908-684-4874

☐ School Nurse
LVMS
51 West Mill Rd.
Long Valley, NJ
07853
908-876-3434
Fax# 908-876-3436

WASHINGTON TOWNSHIP SCHOOLS
Physical Exam for School Entrance/Periodic Physical Exam

Student's Name:_____ Date of Birth:_____

IMMUNIZATION RECORD: Please give exact dates (or attach computer printout)

DTP 1._____ 2._____ 3._____ 4._____ 5._____
Polio 1._____ 2._____ 3._____ 4._____ 5._____
MMR 1._____ 2._____
Hepatitis B 1._____ 2._____ 3._____
HIB 1._____ 2._____ 3._____ 4._____
Varicella 1._____ 2._____ **Meningococcal** 1._____
Hepatitis A 1._____ 2._____ **Most Recent Flu** 1._____
Prevnar 1._____ 2._____ 3._____ 4._____
Mantoux Text: Date of Test:_____ Result:_____ Date Read:_____
Lead Screening: Date of Test:_____ Result:_____

HISTORY OF DISEASES/DATES:

Chicken Pox_____ Lyme Disease_____ Strep Infections_____
Scarlet Fever_____ Hepatitis_____ Meningitis_____
Rheumatic Fever_____ Mononucleosis_____ Other_____

PHYSICAL EXAM:

Height_____ Weight_____ B/P_____
Eyes_____ Vision R 20/_____ L 20/_____ Bilateral_____
Ears_____ Hearing R_____ L_____
Head – Nose/Mouth/Throat/Glands:_____
Respiratory:_____
Cardiovascular:_____
Abdomen:_____
Musculoskeletal/Scoliosis:_____
Neurological:_____
Integument:_____
Hernia:_____

DESCRIPTION OF CONDITIONS/HISTORY:

Asthma/Allergies:_____
Cardiovascular:_____
Ear and Hearing Defects:_____
Diabetes/Endocrine:_____
Neurological/Seizure Disorder:_____
Orthopedic:_____
Surgeries or Serious Injuries:_____
Daily Medications:_____
PRN Medications:_____
Remarks & Recommendations:_____

In view of my physical examination, I believe this child may participate in all physical activities.

Physician's Signature:_____ Date of Exam:_____

Physician's Stamp:_____ Phone:_____