Harrington Park School
Health Services
Pre K-5 Physical Exam Form

In accordance with Board of Education Policy, it is required that all students entering **Pre-Kindergarten**, **Kindergarten** as well as all **new students** return the attached physical examination **prior to school entrance**. In addition, all students **entering grades 2 and 4** are required to have a physical exam. To be acceptable the physical exam must be completed within 12 months of school entrance.
Please return this form to the school nurse.

Child's Name ________________________ Sex ☐ M ☐ F Date of Birth_____________

Vision Screening:

__________ (R) eye _________ (L) eye

Glasses Y/N Contacts Y/N

_________________ Height

______________ Weight

Hearing Screening:

____________(R) ear ___________ (L) ear

Blood Pressure___________________

INDICATORS	NORMAL?	ABNORMAL FINDINGS
General Appearance	YES	
Head/Neck	YES	
Eyes/Sclera/Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose/Mouth/Throat	YES	
Lymph Glands	YES	
Cardiovascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
If murmur present		Standing makes it: Louder Softer No Change
Femoral Pulses	YES	
Lungs: Auscultation	YES	
Chest Contour	YES	
Skin	YES	
Abdomen (liver,spleen,masses)	YES	
Tanner Scale	YES	
Testicular Exam (Males Only)	YES	
Neck/Back/Spine	YES	
Scoliosis	ABSENT	
Upper Extremities	YES	
Lower Extremities	YES	
Hernia	YES	

-OVER-

1. Any defect of vision, hearing or speech that needs
   preferential seating, etc.?....................................... Yes______ No______

2. Any conditions limiting classroom activities?................................. Yes______ No ______
   Limiting Physical Education?... Yes______ No_______

3. Does the child have any allergies to foods or medication?....... Yes_______ No_______

   If yes, please explain____

4. Does the child have any condition which may result in a classroom
   emergency?.. Yes_______ No _______

   If yes, please explain____

5. Does the child have any emotional, mental or physical condition
   requiring periodic medical observation?................................... Yes_______ No_______

   If yes, please explain____

____ ___________________________

Physician's Signature Date

____

PLEASE STAMP WITH OFFICE NAME AND ADDRESS

Child's Name____Date of Birth___________________

Immunizations Mandated by the State of New Jersey, Department of Health and Senior Services

Vaccine Type	1st Dose M/D/Yr	2nd Dose M/D/Yr	3rd Dose M/D/Yr	4th Dose M/D/Yr	5th Dose M/D/Yr	
Diphtheria, Tetanus, Pertussis						
Tdap						
Polio						
Measles, Mumps, Rubella [MMR]						
Haemophilus B [HIB]						
Hepatitis B						
Varicella						
Pneumococcal Conjugate						
Meningococcal				**Hepatitis B**	**Date:**	**Titer:**
Hepatitis A				**Varicella**	**Date:**	**Titer:**
HPV [Human Papillomavirus]				**Measles**	**Date:**	**Titer:**
Influenza				**Mumps**	**Date:**	**Titer:**
Other:				**Rubella**	**Date:**	**Titer:**

Mantoux: Date administered________________ Date read_________________

Results: ☐ Negative ☐ Positive Induration___________mm

Chest X-Ray: Date________________ Results_________________

Medication (if prescribed):_______________________Date started________Date finished________

☐ Provisional Admittance Attached-Date Granted _________ ☐ Medical Exemption Attached

☐ Religious Exemption Attached

____

I certify that the above named child may participate in a normal school program, including Physical Education.

Date of Physical Exam________________

____

Signature of Physician

____

Printed Name

____

Stamp

Harrington Park School Health Office
(201) 768-5700 ext. 38612

LIST OF AUTHORIZED MEDICATIONS THAT MAY BE ADMINISTERED AT SCHOOL

Student's Name________________________________Grade_____School Year____________

The following are the approved over-the-counter/prescription medications in our supply that may be administered at school. Authorizations are effective for one school year. No medication will be administered without PARENT and PHYSICIAN signature.

Name of Medication	Dosage	Reason for use	Frequency	Check if ordered
Tylenol / Acetaminophen	160 mg tabs	Headache / fever / pain	Q 4 hrs	
Tylenol / Acetaminophen	160 mg liquid	Headache / fever / pain	Q 4 hrs	
Tylenol / Acetaminophen	500 mg tabs	Headache / fever / pain	Q 4 hrs	
Motrin / Advil / Ibuprofen	200 mg tabs	Headache / fever / pain	Q 6 hrs	
Motrin / Advil / Ibuprofen	100 mg liquid	Headache / fever / pain	Q 6 hrs	
Benadryl/ Diphenhydramine	12.5 mg liquid	Allergic reaction/ hives	Q 4 hrs	
Benadryl/ Diphenhydramine	25 mg liquid	Allergic reaction/ hives	Q 4 hrs	
Benadryl/ Diphenhydramine	25 mg tab(s)	Allergic reaction/ hives	Q 4 hrs	
Tums	1 tab	Upset stomach		
Hydrocortisone cream	1 %	Itchiness / rash		
Other Medications:				

Parent Signature ____Date_____________

Physician's Signature/Stamp____Date____________