BERKELEY TOWNSHIP SCHOOL DISTRICT

Required Physical Examination for Pupils Entering School

Child's Name____Birthdate_____________M___ F___
(Last) (First) (Middle)

Address____Phone_________________________

Parent/Guardian's Name____

CODE: 0-No Defect 1-Slight Deviation 2-Requires Attention

Hearing: R_____L_____ Glands _____ Posture _____ Extremities ___________

Vision: R_____L_____ Ears _____ Spine _____ Blood Pressure ___________

Throat _____________ Heart _____ Nose _____ Height ___________

Abdomen_____________ Hernia _____ Lungs _____ Weight ___________

Teeth _____________

HISTORY OF: Chicken Pox ______ Pneumonia ______ Heart Disease ______ Allergies ______ Seizures ______

Diabetes ______ Surgeries ______ Chronic Ear Infection ______ Lyme ______ Asthma ______ Other ______

IMMUNIZATIONS REQUIRED:

DPT Immunization: 1. ________ 2. ________ 3. ________ Booster:________ Booster:________

Polio Immunization: 1. ________ 2. ________ 3. ________ Booster:________ Booster:________

MMR: ________ Booster:________ Chicken Pox: ________ Booster: ________

Hep B: 1.________ 2.________ 3. ________

PRESCHOOL IMMUNIZATIONS REQUIRED:

HIB: 1. ________ 2. ________ 3. ________ Pneumococcal: 1. ________ 2. ________ 3. ________ Flu: ________

6TH GRADE IMMUNIZATIONS REQUIRED:

Tdap: ________ Meningococcal: ________

ADDITIONAL IMMUNIZATIONS RECEIVED BUT NOT REQUIRED:

Mantoux: Date: ________ Date Read: ________ Results: ________ Hep A: 1.________ 2.________

RECOMMENDATIONS OR RESTRICTIONS CONCERNING THIS PUPIL:

____

Physician's Signature____Date of Exam______________________

Physician's Stamp____Phone Number______________________

THIS COMPLETED FORM MUST BE RETURNED TO SCHOOL.