WOODBRIDGE TOWNSHIP SCHOOL DISTRICT

School:_____

FAMILY PHYSICIAN'S REPORT

Name of Child (Last, First, M.I.)	Date of Birth (Mo./Day/Yr.)	Sex: ☐ Male ☐ Female
Parent/Guardian — Name:		Home Phone #:
Address:		Cell Phone #:

Vaccine Type	Disease Date	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.	Mo./Day/Yr.
Diphtheria, Tetanus, Pertussis – DTP *(If DT, Td, DTaP, Tdap indicate in corner box)		☐	☐	☐	☐ ☐	☐	☐
Polio Oral Polio Vaccine (OPV) *(If Salk Vaccine indicate (IPV) in corner box)		☐	☐	☐		☐	☐
Measles, Mump Rubella (MMR)							
Measles							
Rubella							
Mumps							
Haemophilus B (HIB)							
Hepatitis B							
Varicella							
Influenza							
Meningococcal							
Pneumococcal Conjugate							
Other (Specify)							

Ht. Wt.	Abdomen	Operation or Injuries	Year
Ears	Hernia		
Eyes	Genito-Urinary (Urinalysis)		
Lymph Glands	Structural		
Thyroid	Orthopedic: Scoliosis		
Nose	Feet		
Throat	Skin (Non Comm.)	Congenital Defects	
Teeth-Mouth	Nutrition		
Heart B/P	Nervous System		
Lungs	Speech		

TB Screening (Mantoux Test):	Vision:	Hearing:
Date Tested:	With Glasses Right	Sweep Check: Right
Date Read:	Left	Left
Result (MM):	Both	Complete Pure Tone: Right
	Without Glasses – Right	Left
	Left	
	Both	

1. Is this child capable of carrying a full program of schoolwork, including physical education activities?
   Yes _____ No _____
2. Should the school program be modified to meet the needs of this child? Yes _____ No _____
3. Is this child taking any medication? Yes _____ No _____
   Please indicate type and reason: _____

_____ Date of Exam

_____ Physician's Name (please print)

_____ Physician's Telephone #

_____ Physician's Signature