Nutley Public Schools
Medical Exam

To Be Completed by Physician: **Date of Exam: _____**

Child's Name: _____, _____ Sex: ( ) Male ( ) Female
Last First

D.O.B.: _____ Height: _____ Weight: _____

Blood Pressure: _____ Pulse: _____ Hearing: _____

Vision: R20/_____ L20/_____ Eyes: _____ Speech: _____

E.N.T: _____ Teeth: _____ Heart: _____

Lungs: _____ Hernia: _____ Urinary: _____

Scoliosis: _____ Orthopedic: _____ Skin: _____

Are there developmental history and/or medical conditions that might affect this child's school experience?

_____

Please list any past illnesses, injuries, or operations. _____

Are there any restrictions or limitations? _____ No _____ Yes If yes, please explain: _____

Immunization Requirements:

D.P.T.: #1_____ #2_____#3_____#4_____ Booster_____Tdap_____ or Td_____
(After 4th Birthday) (After 10th birthday)

Polio: #1_____#2_____#3_____ Booster_____
(After 4th birthday)

MMR: #1_____ MMR: #2_____or Titer_____ Varicella: _____

Hepatitis B: #1_____ #2_____ #3_____

Meningococcal: _____ Mantoux Test: Date_____ Results: _____

Pre- K Only: Pneumococcal Conjugate: _____ Influenza: _____

HIB: #1_____#2_____#3_____#4_____

_____ _____
Physician's Signature _____
_____
Print Physician's Name, Address & Phone #