Watchung Borough Public Schools

BAYBERRY SCHOOL
113 Bayberry Lane
Watchung, N.J. 07069

REMINDER

All Kindergarten physical forms are due in the Bayberry Health Office no later than July 1, 2019. No student will be permitted to enter Bayberry School in September, 2019, without proof of current immunizations as directed by New Jersey State Law. Any questions, please contact the Health Office at 908-755-8184.

New Jersey State Law currently requires all new kindergarten entrants to have:

* Hepatitis B vaccine –Kindergarten – 3 doses HepB vaccine or laboratory evidence of immunity

* DPT – 4 doses with one dose given on or after the 4th birthday or any five doses

* Polio – 3 doses with one dose given on or after the 4th birthday or any four doses

* Measles, Mumps, and, Rubella (MMR)– Two doses, and one being after the 4th birthday

* Varicella – 1 dose on or after first birthday or parental/physician history of diseases or laboratory evidence of immunity

Student's Name: _____ Exam Date: _____

PHYSICAL EXAM

Height:	Weight:	Pulse:	B/P:
Vision:	Uncorrected	Right:	Left:
Vision:	Corrected	Right:	Left:
Hearing Screen:		Right:	Left:

	Normal Exam	**Abnormal Findings:**
Head		
Eyes		
Ears		
Nose		
Throat		
Lymph Glands		
Heart		
Lungs		
Abdomen		
Hernia		
Genitalia		
Skin		
Orthopedic		
Scoliosis		
Neurological		
Speech		
Nutrition		

Physical Exam Comments:

_____

_____

_____

Any Limitation of Activity or other Recommendations? ☐ No ☐ Yes (Please define):

_____

_____

1. If the student will be required to have medications at school such as an Epi-Pen, Asthma inhalers, and other medications for chronic Please fill out the appropriate medication packets.

2. Please attach a copy of the student's immunization records, and include any recent TB screening results.

Physician Signature: _____ Date: _____

Name and Address Stamp:

NEW STUDENT HEALTH AND PHYSICAL EXAM FORM

HEALTH HISTORY (to be filled out by PARENT/GUARDIAN)

Student's Name: _____ Birth Date: _____ Sex ____M ____F

Grade: _____ Languages Spoken at home: _____

Parent / Guardian Name: _____

HEALTH HISTORY

Does the student have or have had any of the following medical conditions:

DISEASE HISTORY	Yes	NO	DISEASE HISTORY	Yes	No
Asthma			Diabetes		
Seasonal Allergies			ADHD/ ADD		
Chronic Otitis Media			Autism Spectrum Disorders		
Lyme Disease			Concussions		
Hepatitis			Neuromuscular Disease		
Rheumatic Fever			Convulsive Disorder		
Strep Infections			Auto Immune Disorders		
Chicken Pox			Juvenile Rheumatoid Arthritis		
Mononucleosis			Congenital Disorders		
Influenza (Flu)			Hematologic Disorders		
Heart Disease			Vision Disorder		
Fractures			Hearing Disorder		

Please provide further details on any "yes" answers:

_____

_____

_____

_____

_____

Operations or Serious Hospitalizations:

_____

_____

_____

Current Medications (Name, Dose, Frequency and Reason used):

_____

_____

_____

Allergies: (Name, reaction to exposure)

Drug: _____

Food: _____

Environmental: _____

Any Other Additional comments or information that you would like to provide:

_____

_____

_____