

PARSIPPANY-TROY HILLS TOWNSHIP SCHOOLS

HEALTH SERVICES

PHYSICAL EXAMINATION FORM – PRE-K – GRADE 5

Name of Student: _____ **Date of Birth:** _____
Sex: M F (circle one) **Age:** _____ **Grade:** _____ **School:** _____
Address: _____ **City, State, Zip:** _____
Home Phone: _____

Health History

(to be completed by the parent)

Has your child had or do they currently have:

a. Any injury, illness, hospitalization or ER visits since their last exam? Y/N

If so, please list: _____

b. Any allergies to foods, bee stings, latex, pollen? Y/N/Don't know

If so, to what? _____

Please describe reaction: _____

c. Does your child currently take any medication prescribed by a doctor or over the counter medication on a daily basis? Y/N

If so, please list: _____

d. Does your child take any medication on an as needed basis?
 (i.e. Epipen, Albuterol inhaler, etc.). Y/N

Please list: _____

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

Parent/Guardian Signature: _____ Date: _____

To be Completed by MD Office

Vaccine Type	Disease MM/DD/YR	1 st Dose MM/DD/YR	2 nd Dose MM/DD/YR	3 rd Dose MM/DD/YR	4 th Dose MM/DD/YR	5 th Dose MM/DD/YR	Booster MM/DD/YR
DPT/DtaP/TdaP (Indicate type)	/ /						
IPV (indicate if OPV)	/ /						
MMR (indicate if separate vaccine)	/ /					Measles Serology	Titer: Date:
Meningitis	/ /					Mumps Serology	Titer: Date:
Hepatitis B	/ /					Rubella Serology	Titer: Date:
Varicella	/ /					TB Screening (Mantoux)	
HIB (Preschool)	/ /					Tested _____	
Influenza (Preschool)	/ /					Read _____	
Pneumonia (Preschool)	/ /					Result _____	
Other	/ /						
Other	/ /						

PLEASE COMPLETE BOTH SIDES

