HILLSIDE ELEMENTARY SCHOOL
Closter, New Jersey

PHYSICAL AND IMMUNIZATION RECORD

Name (Last) _____ (First) _____ Address _____

DOB _____ Parent's name _____ Phone # _____

PHYSICAL REPORT:

HT: _____ WT: _____ BP: _____ Vision: R 20 / _____ L 20 / _____ Hearing: R _____ L _____

WITH / WITHOUT GLASSES

Respiratory _____

Cardiovascular _____

Abdomen _____ Genitalia _____

Musculoskeletal _____ Skin _____

Neurological _____

LABORATORY: Urinalysis _____ HGB/HCT _____ Other _____

RECOMMENDATIONS:

		NO	YES	
1.	Any defect of vision, hearing or speech that the school could compensate for by proper seating, etc?			
2.	Any conditions limiting - Classroom activity? - Physical education?			
3.	Any significant allergies?			
4.	Any condition which may result in classroom emergency?			
5.	Any emotional, mental or physical condition requiring periodic medical observation?			

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 – DPT (If DT or Td indicate in corner of box)							
POLIO ORAL POLIO VACCINE (OPV) If Salk Vaccine, indicate (IPV) in corner of box							
MEASLES, MUPMPS, RUBELLA (MMR)							
MEASLES				Measles Serology:		Date:	Titer:
RUBELLA				Rubella Serology:		Date:	Titer:
MUMPS				Mumps Serology:		Date:	Titer:
VARICELLA							
HAEMOPHILUS B (HIB)							
HEPATITIS B		#1	#2	#3			

	Tested	Read	Result (MM)	CXR (date)	Normal	Abnormal
MANTOUX						

Date of examination: _____

Physician's Signature: _____

Phone Number: _____

STAMP

05/04