JACKSON SCHOOL DISTRICT
Office of Health Services
Entrance Physical Examination
(Physical must be completed within 30 days of enrollment)
TO BE COMPLETED BY PHYSICIAN OR NURSE PRACTITIONER

Student ______________________ Date of Examination ______________________

Address ______________________ Date of Entry ______________________

Phone Number __________ Date of Birth __________ Sex ______ Height ______ Weight ______

Vision __________ Hearing __________ Blood Pressure __________ BMI __________

IMMUNIZATION RECORD *(Exact dates required by law – month/day/year)*

	#1	#2	#3	#4	#5
DTaP (Diptheria, Tetanus, Inactivated Pertussis) Tdap (Tetanus, Diptheria,, Inactivated Pertussis) (Minimum four doses with one dose administered after fourth birthday)					
TdaP (Tetanus, Diptheria, Inactivated Pertussis) One dose prior to entering sixth grade; children more than seven years of age					
IPV (Inactivated Polio Vaccine) OPV (Oral Polio Vaccine) (Minimum three doses with at least one dose given after fourth birthday					
MMR (Given after first birthday)					
MMR Booster (Must be given at least one month after first dose and prior to kindergarten entry)					
HIB Vaccine (Haemophilus Influenza)					
Hepatitis B Vaccine (Three doses series required)					

	#1	#2	#3	#4	#5
Varicella Vaccine (After age one and prior to school entry – 1-2 doses)					
Pneumococcal Conjugate Vaccine (Four shot series required for Preschool)					
Meningococcal Conjugate (One dose prior to entering sixth grade)					
Hepatitis A (Two vaccine series)					
Influenza (One dose annually for preschoolers)					
Mantoux (Check current NJ State Requirements)					

DISEASE HISTORY *(Please specify type and age of onset)*

Allergies	Asthma	Heart Disease
Congenital Defects	Chicken Pox	Otitis Media
Drug Sensitivities	Lyme Disease	Rheumatic Fever
Hepatitis	Convulsive Disorders	Strep Infections
Neuromuscular Disorders	Diabetes	Mononucleosis
Other Illnesses		
Operations or Injuries		

(See reverse)

PHYSICAL EXAMINATION *(Please note every item)*

Ears (Otoscopic)	Heart	Orthopedic:
Eyes	Lungs	Structural
Lymph Glands	Abdomen	Posture
Thyroid	Hernia	Feet
Nose	Genito-Urinary	Skin
Throat	Nutrition	Nervous System
Teeth/Mouth	Speech	General Appearance
Other:		

RECOMMENDATIONS OR RESTRICTIONS (if any): ______________________________

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I have examined this child and find him/her physically fit to participate in all school activities.

*Signature of Physician*______________________________ ______________
(Valid office stamp should accompany signature) *(Date)*

*Physician's Name*______________________________ *Telephone*______________
(Please Print)