REVISED 6/15

JERSEY CITY PUBLIC SCHOOLS

CURRENT GRADE ____________

MEDICAL EXAMINATION

NAME ____ DOB ____/______/_____

ADDRESS ____

HOME PHONE NUMBER ______________________________________

PARENT/GUARDIAN PLEASE NOTE:
A physical examination, including Scoliosis Screening, is required at certain grade levels. This is in compliance with District and State regulations and necessary for the student to take part in interscholastic athletics, intramural sports and regular gym activities.

STUDENT PAST MEDICAL HISTORY
(circle all appropriate answers)

Asthma	When? ____________	Diabetes	When? ____________
Chickenpox	When? ____________	Hepatitis	When? ____________
Heart Disease	When? ____________	Rheumatic Fever	When? ____________
Seizure Disorder	When? ____________	Any chronic illness	When? ____________
			What? ____________

Comments:

____

____

If you circled any of the above items, please provide the following additional information. You may wish to have your claiming physician assist you with the answers.

When was the last episode of the illness?

____

List all the medications that have been required before, during or after any physical activity?

____

____

Are there any restrictions or special instructions related to the student's participation in physical activity or athletic

____

IMMUNIZATIONS: PLEASE BE SPECIFIC: MONTH, DAY & YEAR must be included. SERIES COMPLETE OR IMMUNIZED IS NOT ACCEPTABLE. (CHAPTER 14 NJ STATE LAW) A DT OR TD is recommended if one has not been received within 10 years.

VACCINE TYPE	DISEASE DATE	1ST DOSE	2ND DOSE	3RD DOSE	4TH DOSE	5TH DOSE	6TH DOSE
DTP							
OPV							
MMR							
Measles							
Mumps							
Rubella							
Hepatitis B							
Hib							
DT or TD (circle)							
PCV							
Varicella							
Flu Vac							
Tdap							
HPV							
Meningococcal							
Hepatitis A							

TB Screening (Mantoux Test)				CHEST X-RAY	RESULTS	Therapy
Tested	DATE ______	DATE ______	DATE ______	DATE ______	DATE ______	DATE ______	Case ______
Read	______	______	______	______	______	______	Date Started ______
Results	______	______	______	______	______	______	Date Completed ______ Doses: ______
QuantaFERON Gold-TB	Date: ______	Result: ______					
Lead Level	Date: ______	Result: ______					

PHYSICAL EXAM TO BE COMPLETED BY EXAMINING PHYSICIAN

Height ______ Weight ______
Ears (Otosopic) ______
Hearing R ______ Hearing L ______
Glands: Cervical ______
Vision R/20____________ Vision: R/20____________
Glasses: Yes /No Contacts: Yes/No
Lungs: R ______
Lungs: L ______
Heart RATE: ______ BP: ______

Menstrual Condition: ______
Prone to Dysmenorrhea: ______
Scoliosis Results: ______
Can student participate in gym: ______

Physician's Signature:
____

Date of Visit:
____

Thyroid: ______________________________
Prone to Cold, Allergies, URI's ____ Yes ____No
Hx of middle ear infection? ____ Yes ____No
An episode of Vertigo?: ____ Yes ____No
Abdomen: ______________________________
Skin: ______________________________
Teeth: ______________________________
Extremities: Hx of Fx, sprains, strains, discolorations
____
____
History of Concussion/Head Trauma?
When ______________________________
Return to Play: ______________________________

PHYSICIAN STAMP