DEMAREST PUBLIC SCHOOLS , DEMAREST, NEW JERSEY PHYSICAL AND IMMUNIZATION RECORD Grade _____

Name (Last) (Fin	(First)				Address					
Birthdate Pare	Parent's Name		Phone #							
PHYSICAL REPORT: Ht:	Wt:		BP	BP: Hearing: R			<u> </u>	L		
Vision: R20/L20/				HGB/HCTOther						
Respiratory										
Cardiovascular										
Abdomen Genitalia Skin										
MusculosketalNeurological										
RECOMMENDATIONS			NO	YES	Commen	ts				
Any defect of vision, hearing or speech that the school										
could compensate for by proper seating, etc.?										
2. Any condition limiting classroom activity? Any condition limiting physical education?										
3. Any significant allergies or asthma?										
4. Any condition which may result in classroom emergency?										
5. Any emotional, mental or physical condition requiring periodic medical observation?										
6. Any medication taken on a daily basis?										
VACCINE TYPE	DISEASE	1 ST DOSE	2 nd D		3 rd Dose	4 th Do		5 th Dose	Mo/Day/Yr	
DIPHTHERIA, TETANUS, PERTUSSIS- DTP	DATE	Mo/Day/Y1	mo/l	Day/Yr	Mo./Day/Yr	Mo/D	ay/Yr	Mo/Day/Yr		
(If DT or TD, indicate in corner box)										
POLIO - Oral Polio Vaccine(OPV) (If Salk Vaccine, indicate IPV in corner box.)										
MEASLES, MUMPS, RUBELLA (MMR)										
MEASLES										
RUBELLA										
MUMPS										
VARICELLA										
HAEMOPHILUS B (HIB)										
HEPATITIS B										
Mantoux Date Tested Date Read	d Result(r	nm) CX	R (date)	Norma	al Abno	rmal	Meds	s. Prescribed	(Date)	
Date of examination:Physician's Signature										
Physician's Address										
Phone Number										

1/16