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

Name (Last) (First) Address

Birthdate Parent's Name Phone #

PHYSICAL REPORT: **Ht:**____________**Wt:**____________**BP:**___________ **Hearing: R**__________**L**_________

Vision: R20/_______**L20/**______ **Laboratory:** Urinalysis_____________ HGB/HCT_____________ Other________________
with/without glasses (Circle)

Respiratory____

Cardiovascular____

Abdomen______________________________Genitalia__________________________Skin___________ _____________________

Musculoskeletal____ Neurological____

RECOMMENDATIONS	NO	YES	Comments
1. 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 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- DTP (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	Result(mm)	CXR (date)	Normal	Abnormal	Meds. Prescribed (Date)

Date of examination:________________________Physician's Signature_________________________________

Physician's Address____

Phone Number ____