WYCKOFF PUBLIC SCHOOLS
WYCKOFF, NEW JERSEY

School and Athletic Examination Form

Last Name ________ First Name ________ Address ________ ____/____/____ Date of Birth

Parent's Name ________ Phone ________

DATE OF PHYSICAL EXAM ______/________/________

FINDINGS:

Ht __________________ Wt __________________ BP __________________

Eyes _________ R20/ _________ L20/ _________; Ears _________ Hearing R _______ L _______

Respiratory ____

Cardiovascular ____

Abdomen ____________________ Genitalia ____________________

Musculoskeletal ______________ Scoliosis Exam ______________ Skin ______________

Neurological ____

LABORATORY: Urinalysis ______________ HGB/HT ______________ Other/Lead Level ______________

RECOMMENDATIONS

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

IMMUNIZATIONS

(Insert dates)

_______ DPT _______ DPT _______ DPT

_______ DPT _______ DPT _______ DPT

_______ TET _______ TET _______

_______ OPV _______ OPV _______ OPV

MMR (1) ____/____/____ (2) ____/____/____

MEASLES (LIVE) (1) ____/____/____ (2) ____/____/____

RUBELLA ____/____/____

MUMPS ____/____/____

_______ Hep B _______ Help B _______ Hep B

VARNAX ____/____/____ (2) ____/____/____

_______________ MANTOUX/DATE _______________ RESULTS

COMMENTS:

Phone ________________________________

Physician Signature & Stamp (Required) ________________________________ Date _____/_____/_____