NORTH ARLINGTON PUBLIC SCHOOLS
NORTH ARLINGTON, NEW JERSEY

REPORT OF PHYSICIAN EXAMINING CHILD

REQUIRED FORM TO BE COMPLETED BY PHYSICIAN AND RETURNED TO SCHOOL

_____
(Student's Name)

_____	_____	_____
(Date of Birth)	(Grade)	(School Term)
_____	_____	_____
(Physician)	(Phone)	(Address)

PLEASE DOCUMENT IMMUNIZATIONS BELOW

DPT	1	2	3	4	5
Tdap					
Polio Vaccine	1	2	3	4	5
MMR (or lab evidence of disease)	1	2			
HIB	1	2	3	4	
Hepatitis B	1	2	3		
Varicella	1	2			
Prevnar	1	2	3	4	
Hepatitis A	1	2			
Meningoccal					
HPV					
Other					
Tuberculin Test Type: PPD	Date:		Results:		Chest Xray Date: Results:

HEIGHT	WEIGHT	BLOOD PRESSURE

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
Appearance			Glands		
Nutrition			Heart		
Skin			Lungs		
Head			Abdomen		
Eyes			Reflexes		
Ears			Spine		
Nose			Feet		
Throat			Neurological		
Teeth			Speech		
			Other		

ALLERGIES	VISION	HEARING

COMMENTS:_____
_____

Does this student require any restrictions of physical education activities? (NO) _____ (YES) _____
If yes, specify:
_____

Duration:_____

_____ _____ ***STAMP***
(Physician's Signature) **(Date)**

Revised form 3/11/co