PRIMARY PREP ELEMENTARY
Health History
Kindergarten - New Students -Transfer Students

Student's Name_____Grade:_____

Date of Birth:_____Age:_____ Home Telephone:_____

Address:_____City, State, Zip_____

Physical examinations MUST be submitted for all Students New to the School. The physical must be completed within 3 months prior to school entry into the district and submitted by the first day of school. Immunization records should be up to date and complete with month, day and year. **The Physical MUST be documented on the Primary Prep Elementary Physical Form H2.**

The examination must be completed by a New Jersey licensed MD or Nurse Practitioner.

Please explain "yes" responses on the back.

		Yes	No
1.	Has been medically advised not to participate in any sport, and the reason for such		
2.	Is under a physicians care and the reason for such care		
3.	Has experienced loss of consciousness after an injury		
4.	Has experienced a fracture or dislocation		
5.	Has undergone surgery		
6.	Takes medication on a daily basis: name and reason		
7.	**Has allergies** including bee stings & food allergies Please list: Medications:		
8.	Has experienced frequent chest pains or palpitations		
9.	Has a recent history of fainting with exercise		
10.	Has a recent history of fatigue or undue tiredness		
11.	Has a history of a family member having sudden death		
12.	Has a bleeding tendency		
13.	Has had rheumatic fever		
14.	Has a vision defect: wears glasses/contacts		
15.	Has a loss or seriously impaired function of a paired organ (eye, ear, testicle, kidney)		
16.	Has had a dental check up by a dentist within the year		
17	If the child had a dental check up, did the child have cavities?		

_____ _____

Parent/Guardian Signature **Date**

PRIMARY PREP ELEMENTARY
PHYSICAL EXAMINATION FORM

STUDENT NAME (Last, First, MI)	DATE OF BIRTH	Gender M F
PARENT/GUARDIAN	HOME PHONE	
STREET ADDRESS	CITY, STATE, ZIP	

COMPLETED BY PHYSICIAN: Each area of the examination from MUST BE COMPLETED with Examination results. Checks are NOT adequate documentation of results.

Height:	Weight:	Blood Pressure: /	Allergies?	Taking Medications
Visual Acuity: R: 20/ L: 20/	Glasses: Y N Contacts: Y N	Audiogram Results:	Please List:	Please List:

Abdomen	Eyes:	Skin:
Chest Contour:	Ears:	Head:
Throat:	Heart:	
Teeth:	Rate & Rhythm:	
Genito-urinary: Hernia: Yes No	Neck: Lymph Glands: Thyroid:	Extremities:
Neurological: (Balance & Coordination- Abnormal Reflexes)	Range of Motion:	Spine: Range of Motion: Curvature of Spine:

Additionalcomments:_____

_____

☐ Approved for Physical Activities/Sports/Physical Ed. Classes

☐ Rejected for Physical Activities/Sports/Physical Ed. Classes

Reason:_____

_____

_____ _____

Date of Examination
(must be within 3 months of entry)

Physician* Signature
(*Must be licensed in the State of New Jersey)
PHYSICIAN STAMP & LICENSE NUMBER: