Stanhope Valley Road School
Medical Office

Name:_____ DOB: _____Exam Date:_____

Height:_____ Weight:_____ Temp:_____Pulse:_____ Resp:_____ B/P:_____

Medical History:

Recent Immunizations: _____ Mantoux test: Date:_____ Result:_____

Significant Past Medical History: _____

Prior Hospitalizations: _____ Allergies: _____

Medications: _____

Physical Exam	Normal	Abnormal	Not Examined	Comments
General Appearance				
Speech				
Behavior				
Skin				
Eyes/Vision				
Ears/Hearing				
Nose/Throat/ Mouth				
Heart				
Lungs				
Abdomen				
Bones/Muscles/Joints				
Balance/Coordination				
Reflexes				

Restrictions if any:

_____ _____ _____

Examining Physician (Please Print) Physician's Signature Date

Stanhope Valley Road School
Medical Office

Child's Full Name: _____

Immunizations: State law requires documentation of month, date, year for the following immunizations:

DPT: (Pre-K); 4 doses with one dose given on or after the 4th Birthday or any 4 doses.
(K): 5 doses with one dose given on or after the 4th birthday or any 5 doses

Polio: (Pre-K) 3 doses with one dose given on, or after the 4th birthday.
(k) 4 doses with one dose given on or after the 4th birthday.

MMR: (Pre-K) 1 doses of a measles containing vaccine, on or after 1st birthday.
(K) 2 doses of a measles containing vaccine if born after 1/1/90 or laboratory evidence of Immunity.

Varicella: 1 dose on or after 1st Birthday or Laboratory evidence of immunity/physican history of disease.

Hepatitis B: 3 doses Vaccine or laboratory evidence of immunity.

HIB: 2 doses at 2-11months, 1 dose from 12-59 months. (total 3 doses by 5 years of age)

Pneumococcal: 2 doses at 2-11 months,1 dose from 12-59 months (total 3 doses by 5 years of age).

Flu Shot: 6-59 months, one dose annually. (By December 31 of the school year).

A signed statement of immunizations from your child's physician MUST be presented at registration time.

Medical History: Does your child have a history of :

Allergies	**Heart Disease**
Congenital Defects	**Ear Infections**
Hepatitis	**Strep Infections**
Rheumatic Fever	**Neuromuscular Disease**
Asthma	**Seizures**
Mononucleosis	**Chicken Pox**
Diabetes	**Visual Impairment**
Head Injury	**Hearing Problems**

Please list any Hospitalizations, Injuries or Surgery your child has had:

Please list ANY medications your child takes on a daily basis? Include medication name, and how often taken.

Does your child have any special needs the nurse should be aware of?

_____ _____

Parent Signature **Date**