Rutherford Public Schools
Medical Exam

To be completed by physician: (PLEASE PRINT)

Child's Name: _____ Sex: M [ ] F [ ]
Last First MI

Date of Birth: _____ AGE: _____

Height	Weight	BMI
Eyes	Ears	Lymph Nodes
Pulse	Thyroid	Blood Pressure
Nose	Tonsils	Teeth
Heart	Lungs	Hernia
Urinary	Scoliosis	Orthopedic
Seizures	Speech	Skin (Non-Com.)

Are there developmental history and/or medical conditions that might affect child's school experience?

_____

Are there any restrictions or limitations? No [ ] Yes [ ] **If yes, please explain:**

_____

Immunization Requirements: **All dates MUST include the month, day and year.**

D.P.T. Series #1 _____ #2 _____ #3 _____ #4_____

Booster _____ (after 4th birthday) Tdap Booster (required if born after 1/1/97) _____

Polio Series #1 _____ #2 _____ #3 _____ Booster _____ (after 4th birthday)

Vaccine For: Measles _____ Mumps _____ Rubella _____

MMR#1 _____ MMR #2 _____ Meningococcal Vaccine* _____

Mantoux Tuberculin** Test Date _____ Results _____

Hepatitis B #1 _____ #2 _____ #3 _____

Varicella #1_____ Varicella #2_____ Immunizations given today_____

Flu Vaccine for Pre-K Students*** _____ HIB Series***#1_____ #2 _____ #3____ #4_____

PCV for Pre-K students**** _____

***All students in grade 6 must have Tdap Booster and Meningococcal Vaccine**
****Students entering a N.J. school from a high tuberculosis incidence country must be tested. (Listed in TB guide lines)**
***** One dose due each year by December 31st.**
****** At least one does given on or after the first birthday.**

_____ _____
Physician's Signature Date

Please stamp: Physician's Name: _____ Phone: _____

Physician's Address: _____