BOARD OF EDUCATION **Kinnelon, New Jersey** **STUDENT MEDICAL REPORT**

Name ____________________ Date of Birth ____________________

Address ____________________ School ____________________ Grade ________

IMMUNIZATION RECORD **NJIIS #**

VACCINE TYPE	DISEASE DATE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	6th Dose Mo/Day/Yr
Diphtheria, Tetanus, Pertussis-DTP							
Polio Vaccine (OPV &/ or IPV)							
MMR (Measles, Mumps & Rubella)							
HbPv							
HEPATITIS B							
Varicella							
TB Test (Mantoux)							

DISEASE HISTORY	
Allergies:	Operations
	Chicken Pox
Asthma	Regular Medications
Lyme Disease	
Hepatitis	
Pneumonia	
Strep Infections	
Meningitis	
Otitis Media	
Neuromuscular Disease	
Convulsions	

PHYSICAL EXAM	
Ears (otoscopic)	Heart
Eyes	Lungs
Lymph Glands	Abdomen
Thyroid	Genital-Urinary
Nose	Orthopedic - Posture
Throat	- Structural
Teeth-Mouth	Skin
Nutrition	Height
Nervous System	Weight
Speech	Vision Glasses?
Other	Hearing

Recommendation for physical activity in school:

A. Full Physical Activity ____________

B. Modified Physical Activity because of ____________________

Date of examination: ____________________ Signature of Physician ____________________

Please print physician's name: ____________________

Address: ____________________

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Phone Number: ____________________

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