VISITATION ACADEMY

Paramus, New Jersey

STUDENT PHYSICAL EXAMINATION FORM

All students in Pre-Kindergarten, Kindergarten, Grade 3, Grade 6, as well as all new students attending Visitation Academy, are required to have a physical examination. Please arrange for the necessary examination with your child's doctor and return this completed form to the school nurse.

No child will be allowed to participate in physical education classes without this examination and recommendation by the examining doctor.

NAME_____BIRTH DATE___/_____/_____GRADE: _____

General Appearance: Skin:_____Scalp:_____Acne:_____Eczema:_____

Eyes: Lids_____Conjunctiva:_____Pupils:_____Ears: Canal____Eardrum_____

Height:		Vision:	Without correction	R20/	L20/
Weight:			With correction	R20/	L20/
Blood Pressure:		Hearing:	Right		
Pulse:			Left		

Urine_____Hgb/Hct_____DATE OF EXAM_____/_____/_____

(Protein, sugar)

General Appearance	Skin:	Scalp:	Acne:	Eczema:
Eyes	Lids:	Conjunctiva:	Pupils:	
Nasal Passage:		Throat:	Tonsils:	Teeth:
Ears:	Canal:	Eardrum:		
Neck:		Heart:	Lungs:	Hernia:
Genitalia:		Abdomen:	Menses:	
Orthopedic	Posture:	Spine:	Feet:	Extremities:

Operations: _____ Injuries: _____

Allergies(include food & drug allergies, hives, asthma, insect bites):

_____

_____

Does child take medication on a regular basis? _____ Type:

Reason _____

Any past serious illness? _____

Any current health problems? _____

Full Physical Education Program Recommended? Yes _____ No _____

If Not Recommended, Reason: _____

Significant Family Medical History _____

Educational Relevance of Findings, if any _____

Impact of current Medical Management on Student's Learning Process: _____

IMMUNIZATION RECORD

Vaccine	Mo/Day/YR	Mo/Day/YR	Mo/Day/YR	Mo/Day/YR	Mo/Day/YR
DPT/Td					
Tetanus, Diphtheria & Acellular Pertussis (Tdap)					
Polio					
MMR					
Measles					
Mumps					
Rubella					
HIB					
Hepatitis B					
Varicella					
Meningococcal Vaccine					
Pneumococcal Vaccine					
Influenza Vaccine					
Other					

Mantoux — Date Administered: _____ Date Read: _____

Results:		Negative
		Positive

Indurations: _____ mm

Chest X-Ray: Date: _____ Result: _____

Medication:

Specify:	Date Started	Date Finished
Specify:	Date Started	Date Finished
Specify:	Date Started	Date Finished

Name of Physician _____ Date of Exam _____

[please print]

Physician's Signature _____

VISITATION ACADEMY STUDENT HEALTH QUESTIONNAIRE

Child's Name: _____ Birth Date: _____ Sex: _____

Parents/Guardian _____ Siblings

Age				
Sex				

School: Visitation Academy Interparochial Grade: _____

No.	Question	Yes	No	Explain all "Yes" answers
1	Were there any problems during pregnancy and/or birth?			
2	Do you have any concerns about your child's health? (eating, sleeping, teeth, weight, skin, etc.)			
3	Has your child ever had any eye problems? (difficulty seeing, crossed eyes, squinting, frequently red, watery)			
4	Has your child ever had an eye exam? Date			
5	Does your child wear glasses?			
6	Has your child ever had any ear or hearing problems? (frequent earaches, difficulty hearing, tubes in ears)			
7	Has your child ever has a hearing test? Date: Has your child ever had a hearing evaluation? Date: Result:			
8	Does your child wear hearing aids?			
9	Did your child have any delays in motor skills?			
10	Does your child have any speech problems? (Difficult to understand, stuttering, slow speech development)			
11	Has your child ever had speech therapy? Date			
12	Does your child have any other physical problem or impairment which might affect normal academic progress or participation in the usual school program?			
13	Should there be any restriction of physical activity in school? Include nature and duration or restriction.			
14	Does your child have any psychological, emotional or behavioral problems which might affect school performance?			
15	Has your child had any accidents or illness serious enough to require hospitalization?			
16	Has your child had any broken bones?			
17	Is your child on any daily or long term medication?			
18	Does your child have any health problems which might require emergency action while he/she is at school? (Seizure, insect sting allergy, bleeding problem, diabetes severe asthma, etc.)			
19	Is there a family history of chronic illness or learning problems?			

Child's Name _____ Grade: _____

CONDITION	Yes	No	Date	Explanation
Asthma				
Allergic to drugs				
Allergies – food, environment				
Chicken Pox				
Seizure Disorder				
Diabetes				
Ear infection				
Hearing problems				
Emotional problems				
Heart disease				
Hepatitis				
Kidney disease				
Mononucleosis				
Nosebleeds				
Pneumonia				
Scarlet Fever				
Strep infection				
Speech difficulties				
Concussion				
Fractures				
Operations				
Severe injuries				
Other hospitalization				
Other conditions				
Other injuries				

Is your child currently taking medication? _____ Name of drug(s) _____

_____

If yes, for what condition(s): _____

_____

- I give my permission for the school nurse to share all health information with the faculty as needed

Signature of Parent/Guardian: _____ Date _____

Nurse's Summary: _____