

**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					

Date Administered:

Date Read:

Mantoux

Results:		Negative	Indurations: _____ mm
		Positive	
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 

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 Sex 

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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: \_\_\_\_\_