The Laurel School of Princeton

The Laurel School of Princeton
75 Mapleton Road
Princeton, NJ 08540

**2019-2020**

**PHYSICAL EXAMINATION** *(to be completed by a doctor)*

**STUDENT'S NAME** ______________________________ BIRTH DATE ____________ SCHOOL __________

Height ____________ Weight _____________ Blood Pressure ______________________

Visual acuity Rt _______ Lt _________ Glasses Yes No Hearing Rt ________ Lt __________

Eyes ______________________________ Ears ______________________________

Heart ______________________________ Tonsils ______________________________

Skeletal ______________________________ Nose ______________________________

Skin ______________________________ Glands ______________________________

Hernia ______________________________ Lungs ______________________________

Abdomen ______________________________ Teeth ______________________________

**REMARKS**:

1. Does child have any conditions requiring medical attention? ______________________________
2. Recommendations: ______________________________
3. Does child have any visual disability? No ________ Yes ________
   Define: ______________________________
4. Does child have any hearing disability? No ________ Yes ________ Preferential seating __________________
5. Significant health history (medical and surgical), including dates and comments: ______________________________
   ______________________________
6. Is child receiving medication or other therapy (now or previously)? ______________________________
   ______________________________
7. Diagnostic impressions: ______________________________
   ______________________________
8. Does child have any restrictions of play or physical education activities? ______________________________
   ______________________________
9. What other recommendations do you wish to make to school personnel which will be of benefit to this child? ______________
   ______________________________

***I certify that the above named child was immunized or tested on the following dates (month/day/year):***

IMMUNIZATIONS

| Vaccine Type | Date of Disease | 1st Dose | 2nd Dose | 3rd Dose | 4th Dose | 5th Dose | 6th Dose |
|---|---|---|---|---|---|---|---|
| DTP / DTap | | | | | | | |
| Tdap | | | | | | | |
| IPV / OPV | | | | | | | |
| MMR | | | | | | | |
| HIB ** | | | | | | | |
| Hepatitis B | | | | | | | |
| Varicella | | | | | | | |
| Pneumococcal ** | | | | | | | |
| Meningococcal | | | | | | | |
| Hepatitis A *** | | | | | | | |
| Influenza ** | | | | | | | |
| Mantoux / IGRA | | | | | | | |
| Other | | | | | | | |
| *** Required for preschoolers (2 months – 5th birthday only)* | | | | **** Not required* | | | |

______________________________ ____________ ______________

**Examining Physician's Signature** **Date** **Physician's Stamp**