DEMAREST PUBLIC SCHOOLS , DEMAREST, NEW JERSEY
PHYSICAL AND IMMUNIZATION RECORD **Grade _____**

Name (Last) (First) Address

Birthdate Parent's Name Phone #

PHYSICAL REPORT: Ht:_____Wt:_____BP:_____ Hearing: R_____L_____

Vision: R20/_____L20/_____ **Laboratory:** Urinalysis_____ HGB/HCT_____ Other_____
with/without glasses (Circle)

Respiratory_____

Cardiovascular_____

Abdomen_____Genitalia_____Skin_____ _____

Musculosketal_____ Neurological_____

RECOMMENDATIONS	NO	YES	Comments
1. Any defect of vision, hearing or speech that the school could compensate for by proper seating, etc.?			
2. Any condition limiting classroom activity? Any condition limiting physical education?			
3. Any significant allergies or asthma?			
4. Any condition which may result in classroom emergency?			
5. Any emotional, mental or physical condition requiring periodic medical observation?			
6. Any medication taken on a daily basis?			

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	Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS- DTP (If DT or TD, indicate in corner box)							
POLIO - Oral Polio Vaccine(OPV) (If Salk Vaccine, indicate IPV in corner box.)							
MEASLES, MUMPS, RUBELLA (MMR)							
MEASLES							
RUBELLA							
MUMPS							
VARICELLA							
HAEMOPHILUS B (HIB)							
HEPATITIS B							

Mantoux	Date Tested	Date Read	Result(mm)	CXR (date)	Normal	Abnormal	Meds. Prescribed (Date)

Date of examination:_____Physician's Signature_____

Physician's Address_____

Phone Number _____