

Irene Feldkirchner Elementary School 105 Andrew Street Green Brook, NJ 08812 732-968-1052 ext. 3040 T. Mendez, School Nurse	Green Brook School District History & Physical Exam Report Pre-K, Kindergarten, 1st, 2nd, 3rd & 4th Grades (To be completed by Health Care Practitioner)	Green Brook Middle School 132 Jefferson Avenue Green Brook, NJ 08812 732-968-1051 ext. 2040 L. Ivory, School Nurse
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Student's Name:			
Date of Birth:	Grade:	Gender:	<input type="checkbox"/> male <input type="checkbox"/> female

Disease History (indicate year(s) with positive history and type of disorder if applicable)

AGE	CONDITION	AGE	CONDITION
	Asthma		Diabetes
	Pneumonia		Mononucleosis
	Chronic Bronchitis		Lyme Disease
	Strep. Throat Infection		Chicken Pox (Varicella)
	Otitis Media		Rheumatic Fever
	Heart Disease		Hepatitis
	Seizure or Epilepsy		ADD/ADHD
	Congenital Defects		Dyslexia
	Vision Disorder		Emotional/ Conduct Disorder
	Hearing Disorder		Anorexia

Other: _____

Other History (List procedure, body part and date of occurrence.)

Hospitalizations:
Surgery:
Injuries/ Fractures:
Blood Lead Level = _____³ 10 mg/dL, date performed: _____ <small>NJ State Department of Health requires the actual lead level number- Do not write: "Normal"</small>

Student Immunization Record (Please state date as month/day/year)

Vaccine Type	Disease Date	1 st dose	2 nd dose	3 rd dose	4 th dose	5 th dose	6 th dose
DTP/DTaP/DT/Td							
OPV / IPV							
MMR							
Measles							
Mumps							
Rubella							
HIB							
Hepatitis A -Hep. A							
Hepatitis B -Hep. B							
Varicella							
Meningococcal							
Influenza- Flu							
Pneumococcal							
Rotavirus							
Mantoux (PPD)	Adm. date	Read:	Results:		Adm. date	Read:	Results:

Chest x-ray date: _____ Chest x-ray results: _____

Allergies

Food:
Drugs:
Environmental:

General Exam (indicate any abnormal findings):

Head:	Hernia:
Eyes:	Genitalia:
Ears:	Skin:
Nose/Throat:	Nervous System:
Mouth/Teeth:	Orthopedic:
Lymph glands:	Scoliosis:
Heart:	Speech:
Lungs:	Nutrition:
Abdomen:	Other:

Measurements:

Height (inches)		Weight (pounds)		
Blood Pressure:	Vision & Hearing	Left		Right
	Vision Far:	20/	20/	Glasses on: Yes No
	Near:	20/	20/	Contacts in: Yes No
	Hearing:	dB: Hz.:	dB: Hz.:	Hearing Aid on: Yes No

Medications:

Describe any current ongoing medication therapy (include implications for school).

Physical Activity:

Describe any physical activity restrictions, if applicable.

Growth & Development:

Describe any medical factors that may have affected growth & development.

Learning potential:

Describe any factors that may affect learning.

Additional Comments/Recommendations:

Health care Practitioner's Signature:

Date of Exam: _____

Revised 7-2020

Office Stamp: (printed name, address, & phone)