PHYSICAL EXAMINATION FORM DUE AUGUST 1

SAINT MATTHIAS SCHOOL

170 J.F. Kennedy Boulevard • Somerset, N.J. 08873 • 828-1402

Name of Child (Last, First, M.I.)	Birth Date (Mo/Day/Yr)	Sex ☐ Male ☐ Female

PARENT/GUARDIAN	Name	Phone No.
	Address	

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	6th Dose 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							
MMR (Measles, Mumps & Rubella)							
Measles					or Measles Serology	Date	Titer
Rubella					or Rubella Serology	Date	Titer
Mumps					or Mumps Serology	Date	Titer
Other Hib							

* DT Requires valid medical exemption

Provisional admission attached ☐ Date Granted:

Medical exemption attached ☐

Religious exemption attached ☐

DISEASE HISTORY	YEAR		YEAR		YEAR	OPERATIONS OR INJURIES	YEAR
ALLERGIES		ASTHMA		OTITIS MEDIA			
DRUG SENSITIVITIES		CHICKEN POX		RHEUMATIC FEVER			
LYME DIS.		CONVULSIVE DIS.		STREP INFECTIONS			
HEPATITIS		DIABETES		MONONUCLEOSIS			
NEUROMUSC. DIS.		HEART DISEASE		OTHER		CONGEN. DEFECTS	

Tuberculin Test _____ Type _____ Results _____

Blood Pressure _____ Height _____ Weight _____

Vision R _____ L _____ Hearing R _____ L _____

	Normal	Abnormal	Explanation of Abnormality
Speech			
Oral (teeth, gums)			
Throat/Nose			
Heart			
Glands			
Lungs			
Abdomen			
Hernia			
Orthopedic/Scoliosis			
Nervous System			
Genito-Urinary			

Significant allergies, illnesses, accidents, congenital defects, family history, etc.:
PLEASE LIST ANY MEDICATIONS TAKEN REGULARLY.

Significant factors in family situation:

He/She may participate in all physical activities _____ yes, _____ no. If no, what limitations?

Doctor's Signature _____

Address _____

DATE _____

Phone Number _____