MANASQUAN SCHOOL DISTRICT

Health Service Team

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UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health

Below, please find the copy of the Physical Examination Form that is necessary to register your child for school. The parent/guardian should complete Section I of the form and then submit the form for Section II to be completed by your child's physician.

Please take note of the following:

- **Please attach a copy of immunizations to this form**.
  For incoming PreK 3 & 4 students aged 6 – 59 months on or before December 31, evidence of an Influenza (Flu) vaccination is mandatory before December 31 to enter and remain in the program.

- **Physicals must be completed no more than 365 days prior to the entrance of school.**

- **Vision and Hearing Screening must be completed to be considered a valid physical.**

- **For incoming Kindergarten students, please submit by June 1. If your child turns 5 after June 1, please contact the school nurse.**

- **This form includes all the information required under NJAC 6A:16-2.2 .**

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SECTION I – TO BE COMPLETED BY PARENT(S)			
Child's Name (Last)	**(First)**	**Gender** ☐ Male ☐ Female	**Date of Birth**
Does Child Have Health Insurance? ☐ Yes ☐ No	**If Yes, Name of Child's Health Insurance Carrier**		
Parent/Guardian Name	**Home Telephone Number**		**Work Telephone/Cell Phone Number**
Parent/Guardian Name	**Home Telephone Number**		**Work Telephone/Cell Phone Number**
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.			
Parent/Guardian Signature: _____ Date: _____			**This form may be released to WIC.** ☐ Yes ☐ No

SECTION II – TO BE COMPOLETED BY HEALTH CARE PROVIDER		
Date of Physical Examination	**Results of physical examination normal?** ☐ Yes ☐ No	
Abnormalities Noted:	**Weight** (Must be taken within 30 days for WIC)	
	Height (must be taken within 30 days for WIC)	
	Head Circumference (If < 2 Years)	
	Blood Pressure (if ≥ 3 Years)	
IMMUNIZATIONS ***Please attach***	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____	

MEDICAL CONDITIONS		
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments

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Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities:	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed for the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTATIVE HEALTH SCREENINGS

***Vision, Hearing and Dental Screenings are mandatory for students entering Pre-K**

Parent may submit separate proof of dental

Type of Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			***Hearing**		
Lead: ☐ Capillary ☐ Venous			***Vision**		
TB (mm of Induration)			***Dental**		
Other:			**Developmental**		
Other:			**Scoliosis**		

☐ I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all childcare/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print)	**Health Care Provider Stamp**
Signature/Date	