Irene Feldkirchner Elementary School 105 Andrew Street Green Brook, NJ 08812 732-968-1052 ext. 3040 P. Ostrander, School Nurse	**Green Brook School District** **History& Physical Exam Report** **Pre-K, Kindergarten, 1st, 2nd, 3rd & 4th Grades**	**Green Brook Middle School** 132 Jefferson Avenue Green Brook, NJ 08812 732-968-1051 ext. 2040 J. Esposito, School Nurse

To be completed by Health Care Practitioner

Student's Name:			
Date of Birth:	**Grade:**	**Gender**:	❑ male ❑ 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:
LEAD LEVEL (New Jersey Smart now requires date tested and numeric result if test was performed.) Blood Lead Level = _____ ³ 10 mg/dL, date performed: _____ **NJ State Department of Health requires the actual lead level number- Do not write: "Normal"**

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

Vaccine Type	**Disease Date**	**1st dose**	**2nd dose**	**3rd dose**	**4th dose**	**5th dose**	**6th 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:

Healthcare Practitioner's Signature:

_____

Date of Exam: _____

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