

Little Falls Township Schools- Private Healthcare Provider Physical Examination Form

(To be completed by Private Healthcare Provider)

(Revised NJAC 6A:16-2.2 & NJSA 18A:40-4)

1. Each student must be examined upon entry into the school district. The examination must be done no more than 1 year (365 days) before entry and must state what, if any, modifications are required for full participation in the school program.
2. Parents/guardians must be aware of the importance of obtaining subsequent examinations at least once during each of the student's developmental stages:
 - Early childhood (pre-school through grade 3)
 - Pre-adolescence (grades 4 through 6)
 - Adolescence (grades 7 through 12)

Note to Healthcare Provider: New Jersey students are to receive a current physical examination and recommendations from their healthcare provider, inclusive of a medical diagnosis and etiology for all physical and/or health impairments, prognosis, physical limitations, medications and description of prosthetic devices.

Student: _____ **DOB** _____ **Grade** _____

Please mark "N" for Normal or explain nature of finding.

Height _____ Weight _____ BMI _____

BP _____ Vision w/w-o Glasses _____ Nutrition _____

Eyes _____ Hearing _____ Scoliosis _____

Scoliosis _____ Skin/Scalp _____ Surgical HX _____

Throat _____ Respiratory System _____ Hx of Hospitalizations _____

Asthma Hx _____ RAD _____ Exercise Induced _____

Chronic Health Conditions _____

Immunizations administered during today's visit _____

Does this student have any known allergies and/or allergic reactions? - No _____ Yes _____ (please be specific)

Auto-injector of Epinephrine prescribed - No _____ Yes _____ (Rx must be attached)

Other Emergency Treatment of Allergies _____

Does this student have there any abnormalities in physical, mental, emotional, motor or speech development?
No, ___ Yes, _____ if yes, please explain _____

Does this student have any physical or health impairment, syndrome, chronic illness or acute health condition which might limit strength, vitality or alertness or require adaptation of the educational program? If "yes", please explain: _____

Current Medication: Is this student taking any daily medication at home? No ___ Yes ___ If yes, list and include dosage, frequency, possible side effects

_____/_____-_____-_____/_____
Health Care Provider's Name* Health Care Provider's Tel.# Health Care Provider's Signature /Stamp