

Newton Public Schools

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STUDENT PHYSICAL EXAMINATION

NAME: _____ BIRTH DATE: _____ SEX: M _____ F _____

ADDRESS: _____

DATE OF EXAM _____ HEIGHT _____ WEIGHT _____ BMI _____ BP _____ / _____ PULSE _____

SKIN _____ SCALP _____ EARS: RIGHT _____ LEFT _____ NOSE _____ THROAT _____

TEETH _____ GLANDS _____ HEART _____ LUNGS _____ HERNIA _____ SPINE _____

FEET _____ JOINTS _____ EYES/VISION: RIGHT _____ LEFT _____

PAST HISTORY

AGE

IMMUNIZATION RECORD

CHICKEN POX: _____

DPT: _____

GERMAN MEALSSES: _____

POLIO: _____

MEASLES: _____

MMR: _____

MUMPS: _____

SCARLET FEVER: _____

MEASLES: _____

PNEUMONIA: _____

OTITIS MEDIA: _____

MUMPS: _____

TONSILLITIS: _____

TUBERCULOSIS/INH: _____

RUBELLA: _____

CONVULSIVE DISORDER: _____

NEUROMUSCULAR DISORDER: _____

HIB: _____

CONGENITAL ABNORMALITIES: _____

RHEUMATIC FEVER: _____

HBV: _____

DIABETES: _____

HEART DISEASE: _____

VARICELLA: _____

STREP INFECTIONS: _____

ASTHMA: _____

Tdap: _____ MENINGOCOCCAL: _____

ALLERGIES: _____

LYME DISEASE: _____

Flu Vaccine: _____

MONONUCLEOSIS: _____

TB SCREENING SPECIFY MANTOUX/TINE

HIV VIRUS: _____

TYPE: _____ DATE: _____ RESULT: _____

OTHER: _____

INJURIES: _____

COMMENTS: _____

SURGERY: _____

PHYSICIAN'S NAME: _____

DATE: _____

(PLEASE PRINT)

PHYSICIAN'S PHONE NUMBER: _____

PHYSICIAN'S SIGNATURE: _____



PHYSICIAN STAMP