

BRICK TOWNSHIP PUBLIC SCHOOLS
 Required Pre-School Physical Examination for Pupils Entering **KINDERGARTEN**

Child's Name: (Last, First, Middle) _____

Address: _____ City/State: _____ Phone: _____

Birth Date: _____ Birth Wt: _____ Male: _____ Female: _____

Parent's Name: _____

CODE: 0 – No Defect

1 – Slight Deviation

2 – Requires Attention

E.N.T. R _____ L _____	Heart _____	Spine _____	Height _____
Vision R _____ L _____	Lungs _____	Posture _____	Weight _____
Hearing R _____ L _____	Abdomen _____	Extremities _____	
Teeth _____	Hernia _____	B.P. _____	Glands _____

ILLNESSES:

Chicken Pox _____	Mumps _____	Pneumonia _____	Heart Disease _____
Measles _____	Convulsions _____	Allergies _____	T.B. Contact _____
German Measles _____	Diabetes _____	Scarlet Fever _____	Operations _____
Rheumatic Fever _____	Ear Trouble _____		

VACCINE TYPE	1 ST DOSE MO/DAY/YR	2 ND DOSE MO/DAY/YR	3 RD DOSE MO/DAY/YR	4 TH DOSE MO/DAY/YR	5 TH DOSE MO/DAY/YR	MO/DAY/YR
DIPHTHERIA, TETANUS, PERTUSSIS (DTP) (If Td, DtaP, or Dt*, (Indicate in corner box) One dose on or after fourth birthday.						
POLIO ORAL POLIO VACCINE (OPV) (If Salk Vaccine, indicate IPV in corner box) One dose on or after fourth birthday.						
MEASLES, MUMPS, RUBELLA (MMR) On or after first birthday						
MEASLES (Two doses required)				MEASLES SEROLOGY	DATE	TITER
RUBELLA				RUBELLA SEROLOGY	DATE	TITER
MUMPS				MUMPS SEROLOGY	DATE	TITER
HAEMOPHILUS B (HIB) **						
HEPATITIS B ***						
VARICELLA (Chicken Pox)						
INFLUENZA						
PNEUMOCOCCAL						
Mantoux Tuberculin Test – Date: Only as Required by State Law for Transfer Students						

Recommendations or restrictions concerning this student: _____

Physician's Signature: _____

Date of well child physical: _____

Physician's Stamp:

