Dear Parent/Guardian,

Welcome to the Beverly City School. My name is Alyssa de la Pena and I am the school nurse. One of my duties is to ensure that all of our students are compliant with their immunizations, per New Jersey State regulations. Therefore, prior to your child starting school, I will need evidence of his/her immunization status. Once I have the immunization record that complies with the State requirements, he/she may start school. Also, please have your child's doctor complete the attached physical form. This is also required per the State. Thank you for your cooperation.

Sincerely,

Alyssa de la Pena BSN, RN, CSN-NJ

BEVERLY CITY SCHOOL DISTRICT

Physical Examination Record

Grade_____

_____ _____ _____

Last Name First Birth date Phone

_____ _____

Parent/Guardian Address

_____ _____

Examining Provider Address

_____

IMMUNIZATIONS: Complete immunization record MUST be attached in order for this form to be valid.

If born outside of the USA, must have TB/Mantoux test if the country of origin is deemed to have a high risk of TB exposure by the NJ Department of Health.
(Mantoux test if applicable)

Tested on_____ **Read on**_____ **Result (mm)**_____

EXAMINATION:

Vision: R 20/_____ L 20/_____ Corrected Y/N

Hearing: R Pass/Fail L Pass/Fail **Presence of Scoliosis**: Y/N

Height:_____ Weight:_____ Blood Pressure:_____

Ears (otoscopic)_____ Nervous System_____

Eyes_____ Genitourinary_____

Lymphatic_____ Orthopedic_____

Thyroid_____ Skin_____

Nose_____ Hands_____

Throat_____ Feet_____

Teeth-mouth_____ Speech_____

Heart_____ General Appearance_____

Lungs_____ Other_____

Abdomen_____

_____

_____

_____

_____

CONTINUED

PHYSICAL EXAMINATION RECORD

MEDICAL HISTORY

Allergies_____ Heart Disease_____

Congenital Conditions_____ Otitis Media_____

Drug Sensitivities_____ Strep Infections_____

Hepatitis_____ Mononucleosis_____

Neuromuscular_____ Oncologic Conditions_____

Asthma_____ Operations_____

Varicella History/Date_____ Fractures_____

Diabetes_____ Significant Injuries_____

Mental Health Conditions_____ Hospitalizations_____

_____

Other_____

_____

Medications_____

PROVIDER'S FINDINGS PERTINENT TO SCHOOL

Classification of Physical Activity_____

Full Academic Work Program_____

Follow-up and Notes_____

_____ _____

Signature of Physician/Provider Date of Exam

_____

Print Physician/Provider Name