Farmingdale Public Schools – District Health Services
ELEMENTARY HEALTH EXAMINATION

Student's Name:________________________D.O.B.__________School:______________Grade:________Room:______

PHYSICIAN COMPLETE (*Actual Readings)

*Height:	*Blood Pressure: *Pulse:
*Weight:	Abdomen:
Eyes:	Hernia:
Ears:	Heart:
Vision: w/glasses______w/o glasses_______	Lungs:
Nose & Throat:	Urinalysis: Sugar______Protein________Blood________
Mouth & Teeth:	Orthopedic: *Scoliosis
Skin:	Alllergies: ___Seasonal, ___ Life threatening___Asthma ___Medication

BODY MASS INDEX: __________ __________.__________

WEIGHT STATUS CATEGORY (BMI) PERCENTILE:
___ LESS THAN 5TH ___ 5TH THROUGH 49TH ___ 50TH THROUGH 84TH

___ 85TH THROUGH 94TH ___ 95TH THROUGH 98TH ___99TH AND HIGHER

Specify current diseases: ___ Asthma, ___Diabetes Type 1, ___ Diabetes Type 2, ___ Cholesterol, ___ Hypertension
May student participate in physical education activities?____
Recommendations for adjustment of school program?____
____
Does student require medication? Yes___ No___. If yes, please specify:_______________________________
____

Physician's Signature and Stamp:_______________________________________

Actual date of physical:_____________

IMMUNIZATIONS AND TESTS

Immunizations	Date	Date	Date	Date	Date
	1st Dose	***2nd Dose***	***3rd Dose***	***1st Booster***	***2nd Booster***
Polio					
DPT					
Tdap or TD					
MMR					
Measles					
Mumps					
Rubella					
Hib					
Hep B					
Hep A					
Varicella					
Pneumococcal					
PPD (Tuberculin)					
Meningococcal Vaccine					
Other					

Legal Requirements for Immunization waived because of:
Religious Exemption _____ Medical Exemption _____

(Over------->>>>>)

DISTRICT HEALTH SERVICES
FARMINGDALE PUBLIC SCHOOLS

PARENT COMPLETE:

Student's Name:____________________D.O.B._______Sex____School_________Grade____

(Please circle Yes or No)

1. Has your child ever had any fractures, dislocations, severe sprains or serious injuries? Yes No
2. Has your child ever been hospitalized or treated in the emergency Room? Yes No
3. Has your child ever had surgery? Yes No
4. Does your child have any allergies/and or Asthma? Yes No
5. Does your child take any medications now? Yes No
6. Has your child experienced any type of head injury or concussion? Yes No
8. Does your child wear glasses? Yes No Contact Lenses? Yes No
9. Has your child ever had any illness lasting more than five (5) days? Yes No
10. Any chronic disease? Yes No
11. Do you have knowledge of any heart murmur, high blood pressure, extra heart beat or any other heart abnormality? Yes No

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN BELOW:

____

____

Parent's Signature____ Date________________________

School Physician's Signature:_______________________________Date:_________________