

**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:	Allergies: ___ Seasonal, ___ Life threatening ___ Asthma ___ Medication	

BODY MASS INDEX: _____
WEIGHT STATUS CATEGORY (BMI) PERCENTILE: ___ LESS THAN 5 <sup>TH</sup> ___ 5 <sup>TH</sup> THROUGH 49 <sup>TH</sup> ___ 50 <sup>TH</sup> THROUGH 84 <sup>TH</sup> ___ 85 <sup>TH</sup> THROUGH 94 <sup>TH</sup> ___ 95 <sup>TH</sup> THROUGH 98 <sup>TH</sup> ___ 99 <sup>TH</sup> 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 <i>1<sup>st</sup> Dose</i>	Date <i>2<sup>nd</sup> Dose</i>	Date <i>3<sup>rd</sup> Dose</i>	Date <i>1<sup>st</sup> Booster</i>	Date <i>2<sup>nd</sup> Booster</i>
Polio					
DPT					
Tdap or TD					
MMR					
Measles					
Mumps					
Rubella					
Hib					
Hep B					
Hep A					
Varicella					
Pneumococcal					
PPD (Tuberculin)					
Meningococcal Vaccine					
Other					

<b>Legal Requirements for Immunization waived because of:</b> <b>Religious Exemption _____ Medical Exemption _____</b>
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**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 \_\_\_\_\_

<b>School Physician's Signature:</b> _____ <b>Date:</b> _____
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