WEST MILFORD TOWNSHIP PUBLIC SCHOOLS
STUDENT PHYSICAL EXAMINATION

Date of Exam_____

NAME_____ BIRTH DATE_____ GRADE_____ SEX M_____ F_____

ADDRESS_____ HEIGHT_____ WEIGHT_____

EARS_____ EYES_____ LYMPH GLANDS_____ THYROID_____

NOSE_____ THROAT_____ TEETH/MOUTH_____ HEART_____

LUNGS_____ ABDOMEN_____ HERNIA_____

GENITO-URINARY_____ SPINE/SCOLIOSIS_____ FEET/POSTURE_____

SKIN_____ NUTRITION_____ NERVOUS SYSTEM_____ SPEECH_____

OTHER_____ GENERAL APPEARANCE_____

BP_____ HEARING R_____ L_____ VISION R_____ L_____

**CODE: N-Normal X-Needs Attention

Please circle the appropriate vaccine and types given below for the DPT and Polio sections. It is required by the NJDOH.

PAST HISTORY

DISEASE	AGE
Chicken Pox	
German Measles	
Measles	
Mumps	
Strep Infections	
MRSA	
Pneumonia	
Asthma	
Tuberculosis or Contact	
Otitis Media	
Heart Disease	
Epilepsy/Seizure Disorder	
Congenital Defect	
Rheumatic Fever	
Lyme Disease	
Lead Poisoning	
Allergies: Foods	
Pollen, Grass, Weeds, etc.	
Medications	
Injuries:	
Surgery:	
Hospitalizations:	
Comments:	

IMMUNIZATION RECORD

VACCINE (circle one)	DATES (Month/Day/Year) Date Given
DT DTP Dtap 1	
DT DTP Dtap 2	
DT DTP Dtap 3	
DT DTP Dtap 4	
DT DTP Dtap 5	
TDAP	
OPV IPV 1	
OPV IPV 2	
OPV IPV 3	
OPV IPV 4	
MMR 1	
MMR 2	
HIB 1	
HIB 2	
HIB 3	
HIB 4	
HEP B 1	
HEP B 2	
HEP B 3	
VARICELLA 1	
VARICELLA 2	
PNEUMOCOCCAL CONJUGATE	
INFLUENZA	
MENIMUNE MENACTRA	
GARDISIL	
HEP A 1	
HEP A 2	

Mantoux/TB Test
Date Adm.
_____ Results:_____

Physician's Signature_____

Phone No.:_____

Date:_____

Print or Stamp M.D. name:

NEW STUDENT PHYSICAL AND IMMUNIZATIONS MUST BE UP-TO-DATE, COMPLETED AND SUBMITTED PRIOR TO SCHOOL ENTRY.

Revised 1/2014

WEST MILFORD TOWNSHIP PUBLIC SCHOOLS
BOARD OF EDUCATION
46 HIGHLANDER DRIVE
WEST MILFORD, NJ 07480

Printed Name of Parent/Guardian:_____

ACKNOWLEDGEMENT OF PHYSICAL REQUIREMENT

Date: _____

Dear Parent/Guardian:

New Jersey Law mandates that every student entering a New Jersey public school, regardless of the transferring locations, must present a physical exam signed by a licensed physician. The physical must have been completed within 365 days prior to the first day of school, and it is due in the nurse's office within 30 days of registration. Please make sure you provide the nurse with a written exam report as soon as possible. Your signature below indicates that you have been informed of this policy.

Thank you for your cooperation and attention to this matter.

West Milford Township Public Schools

_____
Parent/Guardian Signature

Revised 11/2017

West Milford Township Public Schools

Good oral health care for your child is an investment in his/her health that will pay lifelong dividends. Regular dental check-ups are an important part of proper oral care. Please have your child's dentist complete this form and return it to the health office.

Report of Dental Examination

Date:_____

Student's Name_____ Age_____

Grade/Teacher _____

Results of Dental Examination

_____ All necessary dental care has been rendered

_____ The child is receiving dental treatment

Comments_____

Date of next dental visit recommended_____

Signature of Dentist_____

Dentist's Printed Name and Address Stamp

Dentist's Telephone No._____

WEST MILFORD TOWNSHIP PUBLIC SCHOOLS
BOARD OF EDUCATION
46 HIGHLANDER DRIVE
WEST MILFORD, NEW JERSEY 07480

RELEASE OF MEDICAL INFORMATION CONSENT FORM

Student's Name: _____
(Please Print)

Parent/Legal Guardian Name: _____
(Please Print)

Please Check One:

_____ I authorize the West Milford Township School Nurses to disclose to the West Milford Township School district employees (i.e., faculty, staff, coaches and volunteers), on a need-to-know basis, medical information from my child's health record (i.e., known medical conditions, allergies, medications).

_____ I do not authorize the West Milford Township School Nurses to disclose information from my child's health record to West Milford School District employees, except when medically necessary. By checking this box, I take full responsibility to disclose said information to District employees and further, I agree to voluntarily release, indemnify, defend and hold harmless the West Milford Board of Education, collectively and individually, as well as its agents, servants, employees and volunteers, from any and all claims which may be brought individually by my/our child or on our/their behalf now and forever, arising out of or connected with, either directly or indirectly, my child's known medical issues, allergies or related emergencies, including medication reactions, caused by any employee or agent's negligence or lack of knowledge related to my child's medical condition.

Parent/Legal Guardian Signature: _____

Date: _____

This consent to disclose information will be valid during your student's entire period of enrollment in the West Milford Township Public Schools. It is your responsibility to update this information annually (i.e., via Emergency Forms) and whenever the student's medical condition/information changes.