STUDENT HEALTH AND PHYSICAL EXAM

HEALTH HISTORY (to be filled out by PARENT/GUARDIAN)

Student's Name: _____ Birth Date: _____ Sex ____M ____F

Grade: _____ Languages Spoken at home: _____

Parent / Guardian Name: _____

HEALTH HISTORY

Does the student have or have had any of the following medical conditions:

DISEASE HISTORY	Yes	NO	DISEASE HISTORY	Yes	No
Asthma			Diabetes		
Seasonal Allergies			ADHD/ ADD		
Chronic Otitis Media			Autism Spectrum Disorders		
Lyme Disease			Concussions		
Hepatitis			Neuromuscular Disease		
Rheumatic Fever			Convulsive Disorder		
Strep Infections			Auto Immune Disorders		
Chicken Pox			Juvenile Rheumatoid Arthritis		
Mononucleosis			Congenital Disorders		
Influenza (Flu)			Hematologic Disorders		
Heart Disease			Vision Disorder		
Fractures			Hearing Disorder		

Please provide further details on any "yes" answers:

_____

_____

_____

_____

_____

Operations or Serious Hospitalizations:

_____

_____

_____

Current Medications (Name, Dose, Frequency and Reason used):

_____

_____

_____

Allergies: (Name, reaction to exposure)

Drug: _____

Food: _____

Environmental: _____

Any Other Additional comments or information that you would like to provide:

_____

_____

_____

Student's Name: _____ Exam Date: _____

PHYSICAL EXAM

Height:	Weight:	Pulse:	B/P:
Vision:	Uncorrected	Right:	Left:
Vision:	Corrected	Right:	Left:
Hearing Screen:		Right:	Left:

	Normal Exam	Abnormal Findings:
Head		
Eyes		
Ears		
Nose		
Throat		
Lymph Glands		
Heart		
Lungs		
Abdomen		
Hernia		
Genitalia		
Skin		
Orthopedic		
Scoliosis		
Neurological		
Speech		
Nutrition		

Physical Exam Comments:

_____

_____

_____

Any Limitation of Activity or other Recommendations? ☐ No ☐ Yes (Please define):

_____

_____

1. If the student will be required to have medications at school such as an Epi-Pen, Asthma inhalers, and other medications for chronic Please fill out the appropriate medication packets.

2. Please attach a copy of the student's immunization records, and include any recent TB screening results.

Physician Signature: _____ Date: _____
Name and Address Stamp:

New Road School of Somerset
2022-2023 School Year

School Nurse Authorization for RX/OTC Medication Administration

This form is to be completed for all medications other than asthma medications and epinephrine.
*Original copy of this form is required by NJ State law.
*State law requires that medication be renewed each school year.
*Only one medication per form.

Name_____ Grade _____ DOB _____Date _____

Diagnosis _____

Allergies_____

Medication _____

Dosage_____ Time/Frequency _____Route_____

Possible Side Effects _____

MEDICATION ORDER FOR CLASS TRIP DAYS (Please note most trips are full day)
___ Dose may be omitted ___ Dose to be given on return to school.
___ Other (please specify):_____

MEDICATION ORDER FOR EARLY DISMISSAL
___ Omit afternoon dose ___ Maintain original order

In the event that the student is not given their morning dose at home, the school nurse may give the medication listed above with parental permission. **AM DOSE:** _____

_____ _____ _____
Provider's Signature **Office Stamp** **Date**

Parent/ Guardian Consent for Giving Medication During School

I request and give my consent for the School Nurse to dispense the medication prescribed by the physician on this form.

A prescription medication must be delivered to the School Nurse in the original pharmacy container labeled with the student's name, date of prescription, name of medication, dosage and the prescribing physician's name. If the medication is an over the counter medicine, it must be in the original box.

I give permission for the information on this form to be shared with the appropriate staff members, coaches, and chaperones for the safety and welfare of my child.

I give permission for the school nurse to speak with the prescribing physician regarding the medication listed above, if necessary.

I request that my child be assisted in taking the medication described below at school by the School Nurse or other individuals authorized to administer medication to students in school pursuant to N.J.A.C:.6A:16-2.3. I understand the ultimate responsibility for administration of the medication is mine, and I am fully aware that the duties of the school nurse and others may require their presence at another location at the time that the medication is needed. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the administration or lack of administration of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of administration or lack of administration of this medication.

_____ _____
Signature of Parent/ Guardian **Date**