5/8/2015

EASTERN CHRISTIAN SCHOOL

Directions for Completing Physical Forms

Welcome to Eastern Christian School! To assist you in preparing for your child's entrance to school, we have prepared a checklist of requirements that need to be met. Please note the highlighted deadlines for each form.

____ ***New Student Physical:*** **Due on or before the first day of school.** A copy of an exam not more than 365 days prior to entrance is acceptable.

____ ***Immunizations*** must be complete and verified on the physical form.

____ ***Mantoux TB Test:*** All students entering Eastern Christian School from another country must have proof of Mantoux test

Preschool 3 or 4	Kindergarten – Grade 4	Middle and High School
_____ 4 DPT _____ 3 Polio _____ 1 Influenza (Given between August & December of current school year. Children 6 months through 59 months attending a child care center) ***The vaccines listed below should be given on or after the child's 1st birthday:*** _____ 1 MMR _____ 1 HIB _____ 1 Pneumococcal _____ 1 Varicella (or proof of the disease immunity)	_____ 4 DPT (1 dose given on or after 4th birthday or 5 doses _____ 3 Polio (1 dose given on or after 4th birthday or any 4 doses) _____ 2 MMR (On or after 1st birthday) _____ 3 Hepatitis B _____ 1 Varicella (Given on or after 1st birthday or proof of the disease immunity)	_____ 3 DPT (boosters recommended every 10 years) _____ 3 Polio _____ 2 MMR _____ 3 Hepatitis B _____ 1 Varicella (For students born on or after 1/1/1998 or proof of the disease immunity) _____ 1 Type ACYW Meningococcal (Students Age 11 or over) _____ 1 Tdap (Students Age 11 or older)

____ ***School Asthma Form:*** If your child has asthma, please request a *School Asthma Form* from your School Nurse's Office. This form needs to be completed and signed by your physician. Asthma forms can also be found at www.easternchristian.org by clicking on *"Parents"* at the top of the page and then on the *"Student Health Forms"tab.*

____ ***Medication Form:*** If it is necessary for your child to receive any medication during school hours, a written request for the administration of the prescribed medication is required from your physician. Forms can be found at www.easternchristian.org by clicking on *"Parents"* at the top of the page and then on *"Student Health Forms."* The medication form can also be obtained from your school nurse.

____ ***Administration of Epinephrine Form:*** If it is necessary for your child to have an epi-pen at school, a written request is required from your physician. Forms can be found at www.easternchristian.org by clicking on *"Parents"* at the top of the page and then on *"Student Health Forms."* The medication form can also be obtained from your school nurse.

_____ ***Sports Forms:*** If your child is participating in a sport during the school year, please have the physician also complete a *Sports Physical Form*. These forms can be found at www.easternchristian.org under *"Athletics"* and then click on *"Forms."* **FOLLOW THE DIRECTIONS GIVEN ON THAT PAGE.** ***If your child is participating in a fall sport, sports forms must be received before August 1.***

Completed forms can be mailed to "Attention School Nurse" for the campus your child attends:

Eastern Christian Elementary School
25 Baldin Drive
Midland Park, NJ 07432

Eastern Christian Middle School
518 Sicomac Avenue
Wyckoff, NJ 07481

Eastern Christian High School
50 Oakwood Ave
North Haledon, New Jersey 07508

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PHYSICAL EXAMINATION REPORT

(Due before the first day of entrance to school)

Student's Name: _____ Phone: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip)

Date of Birth: _____ Sex: _____ Grade Level in September: _____

Mother's Name: _____ Father's Name: _____

Address:_____ Address: _____

_____ _____

Phone: _____ Phone: _____

New Student from: _____
(School) (City) (State)

Student's Medical History

(To be completed by Parent or Physician)

	YES	NO	Description/Reason
Allergies			
Asthma			
Blood Disorders			
Cancer			
Chicken Pox			
Diabetes			
Headaches			
Hearing Problems/Hearing Aide			
Heart Disease			
Anxiety/Depression			
High/Low Blood Pressure			
Hospitalizations			
Kidney/Urinary Tract Problem			
Medication Reactions			
Menstrual Disorder			
Mononucleosis			
Muscular Disorder			
Orthopedic Disorder			
Rheumatic Fever			
Scoliosis			
Seizure Disorder			
Strep Infections			
Surgery			
Ulcer/Gastrointestinal Disorder			
Visual Problem/Glasses/Contact Lenses			
Other			

Is the student now under the care of a physician? _____

Does the student take any regular medication? Please name medication and dosage: _____

_____

Has the student ever been advised by a physician not to play a sport? _____

Are there any other physical or emotional conditions that might affect this child's abilities or performance? _____

COMMENTS: _____

TO BE COMPLETED BY PHYSICIAN

Student's Name: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision without Correction: R20/_____ L20/_____ Both 20/_____

Vision with Correction: R20/_____ L20/_____ Both 20/_____

Hearing: Right: _____ Left: _____

Nutrition (Please note significant weight gain or loss in the last year): _____

Head & Neck: _____ Lungs: _____ Extremities: _____

Nose: _____ Heart: _____ Neurological: _____

Eyes: _____ Abdomen: _____ Urinalysis: _____

Ears: _____ Back: _____ Hemoglobin: _____

Throat: _____ Genitalia: _____ Scoliosis Screening: _____

If positive, Treatment? _____

Chest/Breast: _____ Hernia: _____

Comments: _____

- **Based on this history/physical, this student: Doctor-Please make sure you complete this section. Thank you!**

  _____may participate in competitive athletics and physical education activities.

  _____has health problems, which prohibit participation in the following athletic activities: _____

  _____

A. **New Students:** Complete information for all immunizations must be submitted. Please include month, day and year for each immunization.
Returning Students: Please note date of last booster and any other immunization that has been given in the last year.

VACCINE TYPE	1ST Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Hr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	LEAD SCREENING	
Diptheria, Tetanus, Pertussis – (DTaP) *If Td or DT, write in corner box)							
Tdap (not Td)							
Polio-Inactivated Vaccine (IPV) If oral polio, write (OPV) in corner box							
MMR (Measles, Mumps & Rubella					Document below single antigen vaccine receipt, serology titers, or varicella disease history		
Haemophilus B (HIB)**					Hepatitis B	Date:	Titer:
Hepatitis B					Varicella	Date:	Titer:
Varicella					Measles	Date:	Titer:
Pneumococcal Conjugate**					Mumps	Date:	Titer
Meningococcal (Meningitis-ACYW must be noted)					Rubella	Date:	Titer:
Hepatitis A***							
Influenza**							
HPV (Human Papillomavirus)**							
Other (Specify)							
*DT Requires valid medical exemption **Required for Day/Child Care (2m-5yo)	Medical exemption attached ☐ *** Not Required			Religious exemption attached ☐ Provisional admissions attached ☐ Date Granted:			

B. **Mantoux Tuberculin Test: Date:_____Result:_____If positive, did student have chest X-ray?____Result?_____**

Physician's Signature: _____ Date **of Examination:** _____

Physician's Name: _____ **Address:** _____

_____ **Telephone:** _____