HARRISON TOWNSHIP SCHOOL DISTRICT

REPORT OF STUDENT PHYSICAL EXAMINATION

Student Name: _____ Gender: M F Birthdate: _____

Date of Exam: _____ Height: _____ Weight: _____ B.P. _____

Review of Systems:

Head and Neck: _____

Vision/Hearing Screenings/Evaluations (date/results) _____

Respiratory _____

Cardiovascular _____

Gastrointestinal _____

Musculoskeletal _____

Neurological _____

Skin _____

Significant Health History: _____

_____

Surgical Procedures: _____

_____

Allergies: _____

Chronic Conditions: _____

Developmental Delays: _____

_____

Prescribed Medications: _____

Please list any concerns/recommendations/restrictions/modifications required for participation in the school program: _____

_____

_____

Physician's Signature

Physician Name: _____

Office Address: _____

Office Phone: _____

Revised 10/3/07

IMMUNIZATION HISTORY

DTP _____

OPV _____

MMR _____

HIB _____

HBV _____

Varicella _____

(Optional) The lead level determined by your child's last lead test:

_____

Level Day Month Year

EXHIBIT C – MEDICAL CONTRAINDICATION (VA-18)

If an immunization is contraindicated for medical reasons, the VA-19 should be completed by the pupil's health care provider. It must be kept as part of the pupil's permanent immunization file. The medical contraindication must state both the reason and the length of the medical contraindication, and be signed by a physician licensed to practice medicine or osteopathy in any jurisdiction in the United States.

New Jersey State Department of Health
Medical Contraindication
School Immunization Record Series

Upon Completion
To Be Attached To
Standard Immunization Record

Name of Child (Last, First, M.I.)	Birth Date (Mo/Day/Yr)	Sex Male Female

The following immunizations are medically contraindicated and constitute a threat to the child's health.

ANTIGENS: _____

Reason for exemption: _____

_____

_____

_____

_____

This exemption shall continue until: _____.

Print Name and Address of Physician	Telephone
Signature	Date