REVISED 3/23

JERSEY CITY PUBLIC SCHOOLS
MEDICAL EXAMINATION

CURRENT GRADE _____

NAME _____DOB _____/_____/_____

ADDRESS _____

HOME PHONE NUMBER _____

PARENT/GUARDIAN PLEASE NOTE:
A physical examination, including Scoliosis Screening, is required at certain grade levels. This is in compliance with District and State regulations and necessary for the student to take part in interscholastic athletics, intramural sports and regular gym activities.

STUDENT PAST MEDICAL HISTORY
(circle all appropriate answers)

Asthma	When? _____	Diabetes	When? _____
Chickenpox	When? _____	Hepatitis	When? _____
Heart Disease	When? _____	Rheumatic Fever	When? _____
Seizure Disorder	When? _____	Any chronic illness	When? _____
			What? _____
Allergies	To what? _____		
	Reaction? _____		

Comments:
_____

_____

If you circled any of the above items, please provide the following additional information. You may wish to have your claiming physician assist you with the answers.

When was the last episode of the illness?
_____

List all the medications that have been required before, during or after any physical activity?
_____
_____

Are there any restrictions or special instructions related to the student's participation in physical activity or athletics?_____

NAME _____DOB _____/_____/_____

IMMUNIZATIONS: PLEASE BE SPECIFIC: **MONTH, DAY & YEAR must be included**. "***SERIES COMPLETE" or "IMMUNIZED" is NOT ACCEPTABLE***. (CHAPTER 14 NJ STATE LAW) A DT OR TD is recommended if one has not been received within 10 years.

ATTACH A COPY OF THE UPDATED IMMUNIZATION RECORD

VACCINE TYPE	DISEASE DATE	1ST DOSE	2ND DOSE	3RD DOSE	4TH DOSE	5TH DOSE	6TH DOSE
DTaP							
Tdap							
IPV							
MMR							
Measles							
Hepatitis B							
HIB							
DT or TD (circle)							
PCV							
Varicella							
Meningococcal							
Hepatitis A							
HPV							
Flu Vac							
COVID 19 Moderna							
COVID 19 Pfizer							
COVID 19 Johnson							

TB Screening (Mantoux Test)				CHEST X-RAY	RESULTS		Therapy
Tested	DATE _____	DATE _____	DATE _____	DATE _____	DATE _____	DATE _____	Case_____ Date Started _____
Read Results	_____	_____	_____	_____	_____	_____	Date Completed _____
	_____	_____	_____	_____	_____	_____	Doses: _____
QuantaFERON Gold-TB	Date: _____	Result: _____					
Lead Level	Date: _____	Result: _____					

PHYSICAL EXAM TO BE COMPLETED BY EXAMINING PHYSICIAN - Complete by *30 days* of notice

Height _____ Weight _____ BMI_____

Lungs: R _____ Lungs: L _____

Heart RATE: _____ BP: _____ /_____

Glands: Cervical _____ Thyroid: _____

Ears (Otoscopic) _____

Hearing R _____ Hearing L_____

Vision R/20_____ Vision: R/20_____

Glasses: Yes /No Contacts: Yes/No

Menstrual Condition: _____

Prone to Dysmenorrhea: _____

Scoliosis Results: _____

Can student participate in gym: _____

Physician's Signature:

_____

Date of Visit: _____

Prone to Cold, Allergies, URI's ____ Yes ____No

Hx of middle ear infection? ____ Yes ____No

An episode of Vertigo?: ____ Yes ____No

Abdomen: _____

Skin: _____

Teeth: _____

Extremities: Hx of Fx, sprains, strains, dislocations

_____

_____

History of Concussion/Head Trauma?

When _____

Return to Play: _____

PHYSICIAN STAMP