

North Haledon School District

DONNA L. CARDIELLO, M.ED.
 SUPERINTENDENT OF SCHOOLS
 973-427-1220

GIOVANNI A. GIANCASPRO, M.SPED.
 PRINCIPAL, MEMORIAL SCHOOL
 973-427-8993

NANCY DI BARTOLO
 BUSINESS ADMINISTRATOR/
 BOARD SECRETARY
 973-427-8178

Health Examination

Dated Examined _____

Student's Name _____ DOB _____ School/Grade _____

IMMUNIZATION DATES

DPT	_____	_____	_____	DPT/DT	_____	_____	_____
Polio	_____	_____	_____	Polio	_____	_____	_____
Hib/Prohibit	_____	_____	_____	Hib/Prohibit	_____	_____	_____
				Tetanus	_____	_____	_____
MMR	_____	_____	_____				
Hepatitis B	_____	_____	_____	Gardasil	_____	_____	_____
Varicella	_____	_____	_____	Pneumococcal	_____	_____	_____
Influenza	_____	_____	_____				
Hepatitis A	_____	_____	_____	Meningococcal	_____	_____	_____

Tuberculin Test: _____ Result: _____

Mantoux: _____ Result: _____ X-Ray date: _____
 (only if required)

Examination Reveals the Following Significant Findings:

Height	_____	Weight	_____	Urinalysis	_____
Hemoglobin	_____	B/P	_____	Abdomen	_____
Nutrition	_____	Throat	_____	Genito-urinary	_____
Skin	_____	Glands	_____	Hernia	_____
Eyes	_____	Heart	_____	Orthopedic	_____
Ears	_____	Lungs	_____		
Nose	_____				

Allergies: _____ Operations (dates) _____

Injuries(dates) _____ Illnesses(dates) _____

Scoliosis Screening
 Ages 10 – 18 Results _____

Please complete other side!

Supplemental Information – MUST BE COMPLETED

1. History of syncope, concussion, skull fracture? YES _____ NO _____

2. Serious visual defect or loss of vision in eye/eyes? YES _____ NO _____
3. Hernia, Hydrocele or loss of one kidney or testicle? YES _____ NO _____
4. Previous joint injuries not healed or repaired? YES _____ NO _____

General physical and emotional status _____

Does this pupil take any medication regularly? ___NO ___YES If yes, complete below:

Purpose of medication (Diagnosis) _____

Medication(s): _____

When is medication administered: _____

Possible side effects of medication: _____

RECOMMENDATIONS FOR ANY ADJUSTMENT IN SCHOOL PROGRAM SHOULD BE NOTED BELOW:

_____ is in _____ condition and may
safely engage in all usual activities, except as noted:

Physician's Signature

Physician's Stamp/Address/Phone #