

PRE-K to KINDERGARTEN

St. Aloysius Elementary School Health Office

935 Bennetts Mills Road, Jackson, NJ 08527 - Telephone: 732-370-1515 Fax: 732-370-3555

Student Name _____ Grade _____ Date of Birth _____

Address _____

Parent/Guardian _____ Phone No. _____

In order for your child to enter Kindergarten, a new physical exam and proof of the following inoculations must be submitted to the Health Office by May 1st.

5 doses of DPT (Diphtheria, Pertussis, Tetanus)

4 doses of OPV or IPV (Polio Vaccine)

3 doses of Hep. B (Hepatitis B)

2 doses of MMR (Measles, Mumps, Rubella)

1 dose of Hib

1 dose Varivax

D.P.T. 1. _____	2. _____	3. _____	4. _____	5. _____
O.P.V. 1. _____	2. _____	3. _____	4. _____	
Hep. B 1. _____	2. _____	3. _____		
M.M.R. 1. _____	2. _____			
Hib 1. _____				
Varivax 1. _____				

Disease History (include dates)

Allergies _____	Hepatitis _____	Asthma _____
Lyme Disease _____	Chicken Pox _____	Diabetes _____
Otitis Media _____	Mononucleosis _____	Heart Disease _____
Neuromuscular Disease _____	Convulsive Disorder _____	Others _____

Physician's Examination Date _____

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Legend: N = normal X = abnormal NE = not examined

Eyes _____	Ears _____	Nose _____	Throat _____	Teeth _____
Neck _____	Lungs _____	Heart _____	Chest _____	Liver _____
Spleen _____	Spine _____	Abdomen _____	General body build _____	

Joint Function:

Neck _____	Shoulders _____	Elbows _____	Wrists _____	Hands _____
Hips _____	Knees _____	Ankles _____	Feet _____	Hernia _____
Neurological _____				

Operations or injuries during the past year _____

Vision with glasses Right _____ Left _____ without glasses Right _____ Left _____

Hearing Sweep Check Right _____ Left _____ or Pure Tone Right _____ Left _____

Any Problems with Speech? _____

I certify that I have examined this student as indicated and find him/her physically fit to participate in all supervised activities at St. Aloysius School.

Physician's signature _____

Physician's printed signature _____

Please stamp above

PLEASE RETURN THE COMPLETED FORM TO THE SCHOOL NURSE BY MAY 1.