

SOMERDALE PARK SCHOOL

Mary E. Dow, RN BSN CSN
School Nurse

Health Office
301 Grace Street
Somerdale, New Jersey 08083

Telephone: 856-783-6261 X115
Fax: 856-783-2607

PRE-K/KINDERGARTEN MEDICAL EVALUATION

Please have examination done and form completed in full by your private physician.

New Jersey State Administrative Code-Title 6A, Chapter 16 & School Board Policy requires that this form be completed and returned to the School Nurse for all Pre-School or Kindergarten students *PRIOR* to admission to school

The date on the physical form must indicate that, the physical was provided by your Medical provider within the last 365 days

STUDENT'S NAME: _____ ADDRESS: _____

BIRTHDATE: _____ AGE: _____ GRADE: _____ TEACHER: _____

HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____ HR: _____ RR _____

HEAD:

Eyes: physical exam
Vision exam:

Ears:
Nose:
Throat:
Neck:

GENITALIA:

Hernia:
Hydrocele:
Undescended testicles

EXTREMITIES:

CHEST:

Heart:
Lungs:
Rib Cage:

NERVOUS SYSTEM:

Reflexes:
Coordination:
Gross Motor:
Fine Motor:

ABDOMEN:

SKIN:

SPINE:

Posture:
Scoliosis Screening: (age 8 & over)

GLANDS:

Cervical:
Axillary:
Inguinal:

FEET:

GAIT:

REMARKS:

Please Complete Reverse Side Also

**Please complete form for all immunizations or attach a copy of complete immunization record
Please be aware as per N.J.A.C.8:57-4- All students must provide proof of receiving required immunizations for
attendance in NJ Public Schools; if not in compliance students will NOT be admitted until compliant**

IMMUNIZATION RECORD
Immunizations Required for Pre-school Entry

4 doses DTP/Dap #1 _____ #2 _____ #3 _____ #4 _____

1 dose Haemophilis influenzae B (HIB) #1 _____ #2 _____ #3 _____ #4 _____

3 doses Polio Vaccine #1 _____ #2 _____ #3 _____

1 dose MMR #1 _____ (must be given after 1st birthday)

3 doses Hep B #1 _____ #2 _____ #3 _____

Varicella Vaccine #1 _____

***New! PCV (Pneumococcal Conjugate Vaccine): (@ least 1 dose on or after 1st birthday) #1 _____

***New! Influenza Vaccine: All Children 59 months or less entering a PreSchool Facility must have (1) dose Of Influenza Vaccine between September 1st & December 31st of each year & submit proof of receipt to School by January 1st.

Immunizations Required for Kindergarten Entry

4 doses DTP/DTaP #1 _____ #2 _____ #3 _____ #4 _____ (#5 _____)
(ONE DOSE MUST HAVE BEEN GIVEN ON OR AFTER 4TH BIRTHDAY)

3 doses Polio Vaccine #1 _____ #2 _____ #3 _____ (#4 _____)
(ONE DOSE MUST HAVE BEEN GIVEN ON OR AFTER 4th BIRTHDAY)

2 doses MMR #1 _____ #2 _____
(1st dose must have been given after 1st birthday; 2nd dose required for all children born on or after Jan. 1, 1990 and must be separated by at least 28 days from the 1st dose)

3 doses Hepatitis B Vaccine #1 _____ #2 _____ #3 _____
(Now required for all children born on or after Jan. 1, 1996)

Varicella Vaccine #1 _____ #2 _____ PCV#1 _____ HepA #1 _____

Date Of Exam: _____ DR.'s Signature: _____
Dr.'s Name: :(PleasePrint): _____ Phone#: _____
Address: _____