



**Saint James
Elementary School**

30 Peters Place
Red Bank, NJ 07701

School Nurse
Mrs. Marie Lehmann

Office Hours:
Monday-Friday 7:30 am to 3:00pm

Health Examination Form

General Information:			
Student's Name: _____	Grade: _____		
Address: _____	Physician's Name: _____		
City: _____	Physician's Address: _____		
State and Zip Code: _____	Physician's Phone No. _____		
Home Phone No. _____			
Age: _____	Date of Birth: _____	Sex: <input type="checkbox"/> Male	<input type="checkbox"/> Female
Height: _____	Weight: _____	Blood Pressure: _____	

Immunization History:	Date Administered	Date Administered	Date Administered	Date Administered	Date Administered
DTP					
Polio (Indicate Oral or IPV)					
Measles		Mumps		Rubella	
MMR					
HIB					
Hepatitis B					
Chicken Pox Vaccine					
Other					
	Date Administered	Date Read	Results (MM)		
Mantoux TB					

General Health Information:	Normal	Abnormal	Comments
Head and Neck			
Eyes (Eyeglasses __Yes __No)			
Ears			
Nose			
Throat			
Teeth			
Heart			
Lungs			
Abdominal			
Musculo-Skeletal/Scoliosis			
Skin			
Neurological			
Genitalia			
Other			
Known Allergies:			

Presently taking medication? No Yes If yes, will this be taken during school? No Yes
All medications taken during school must have a doctor's prescription/order to the school nurse for the school year.

Restriction in Physical Education? No Yes
If yes, Please explain: _____

Physician's Signature: _____ Date: _____

Please Print Physician's Name: _____