

## HASBROUCK HEIGHTS PUBLIC SCHOOLS PHYSICAL EVALUATION FORM

**(PARENTS TO FILL OUT)**

**-STUDENT INFORMATION-**

Student's Name: \_\_\_\_\_ Sport: \_\_\_\_\_  
 Sex: M F (circle one) Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 School: \_\_\_\_\_ District: \_\_\_\_\_  
 Parent/Guardian's Full Name: \_\_\_\_\_

**PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH PAGES**

**Examination Date:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_/\_\_\_\_ Pulse: \_\_\_\_\_

Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y / N Contacts: Y / N Glasses: Y / N Hearing: R \_\_\_\_ L \_\_\_\_

Indicators	Normal? (Circle One)		Abnormal Findings/Comments
	YES	NO	
Head/Neck	YES	NO	
Eyes/Sclera/Pupils	YES	NO	
Ears	YES	NO	
Nose/Mouth/Throat	YES	NO	
Heart: Murmurs/Rhythms	YES	NO	
Lungs: Auscultation/Percussion	YES	NO	
Chest Contour	YES	NO	
Skin	YES	NO	
Abdomen: Assessment (incl. liver, spleen)	YES	NO	
Tanner Stage: Testes/Onset of Menses:	YES	NO	
Neck/Back/Spine: Range of Motion:	YES	NO	
Scoliosis:	YES	NO	
Upper Extremities:	YES	NO	
Lower Extremities:	YES	NO	
Neurological: Balance & Coordination: Romberg:	YES	NO	
Heel Walk:	YES	NO	
Tandem Walk:	YES	NO	
Nose Touch:	YES	NO	
Toe Walk:	YES	NO	
Hernia? (if yes/possible, please explain)	YES/ Possible	NO	

Most recent immunizations/Dates:
Medications currently being used:
Additional Observations:

General Diagnosis: \_\_\_\_\_

Recommendations: \_\_\_\_\_

**CLEARANCES**

**A. Student MAY participate in the following sports: (CHECK ALL THAT APPLY)**

CONTACT/COLLISION  
 LIMITED CONTACT

NON-CONTACT/STRENUOUS  
 NON-CONTACT/NON-STRENUOUS

**SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT**

Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Field Hockey	Baseball	Discus	Bowling
Football	Basketball	Javelin	Golf
Ice Hockey	Cheerleading	Shot put	
Lacrosse	Diving	Rowing	
Soccer	Fencing	Running/Cross Country	
Wrestling	Field	Strength Training	
	High Jump	Swimming	
	Pole vault	Tennis	
	Gymnastics	Track	
	Skiing		
	Softball		
	Volleyball		

**B. Student MAY participate in following sport(s) ONLY AFTER completing evaluation/rehabilitation:(CHECK ALL THE APPLY)**

CONTACT/COLLISION  
 LIMITED CONTACT

NON-CONTACT/STRENUOUS  
 NON-CONTACT/NON-STRENUOUS

Please specify each condition requiring clearance before participating in a sport in the classification checked above:

\_\_\_\_\_

\_\_\_\_\_

*Conditions requiring clearance before sports participation include, but are not limited to: Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.*

**EXAMINED BY:**

Family Physician/Provider \_\_\_\_\_  
School Physician \_\_\_\_\_  
 MD  DO  NP  PA

**Physician's/Provider's Stamp:**

**NOTE TO SCHOOL PHYSICIANS:** Pursuant to N.J.A.C. 6A:16-2.2, the school physician shall provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this medical report. Please attach this form to the notification letter and ensure that this report is made part of the student's permanent health record.

**HASBROUCK HEIGHTS PUBLIC SCHOOLS  
SCHOOL HEALTH SERVICES  
Hasbrouck Heights, NJ, 07604**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

School: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Dear Parent / Guardian:

According to the New Jersey State Sanitary Code, Chapter 14: Administrative Code 8:57-4:17, no pupil may enter in a school who has not submitted acceptable evidence of immunization against disease to the School Health Office.

**THE RECORD MUST CONTAIN THE NAME, ADDRESS & PHONE NUMBER OF THE PHYSICIAN**

**New Jersey Department of Health and Senior Services  
STANDARD SCHOOL / CHILD CARE CENTER IMMUNIZATION RECORD**

NAME OF CHILD (Last, First, MI)					DATE OF BIRTH (Mo./Day/Yr.)		SEX <input type="checkbox"/> M <input type="checkbox"/> F	
NAME OF PARENT/GUARDIAN					TELEPHONE NUMBER(S)			
ADDRESS								
ADDRESS					IMMUNIZATION REGISTRY NUMBER			
VACCINE TYPE	1ST DOSE MO/DAY/YR	2ND DOSE MO/DAY/YR	3RD DOSE MO/DAY/YR	4TH DOSE MO/DAY/YR	5TH DOSE MO/DAY/YR	LEAD SCREENING (Not Required)		
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT <sup>11</sup> , indicate in corner box)						TEST DATE	RESULT	
POLIO-INACTIVATED POLIO VACCINE (IPV) (If oral vaccine, indicate OPV in corner box)								
MEASLES, MUMPS, RUBELLA (MMR)						(5) Document below single antigen vaccine receipt, serology titers, or varicella disease history		
HAEMOPHILUS B (HIB) (2)								
HEPATITIS B (3)						Hepatitis B	DATE:	TITER:
VARICELLA (4)						Varicella	DATE:	TITER:
PNEUMOCOCCAL CONJUGATE (2)						Measles	DATE:	TITER:
INFLUENZA (6)						Mumps	DATE:	TITER:
OTHER, SPECIFY:						Rubella	DATE:	TITER:
<input type="checkbox"/> Provisional Admission Attached - Date Granted: _____ <input type="checkbox"/> Medical Exemption Attached <input type="checkbox"/> Religious Exemption Attached								

(1) REQUIRES MEDICAL EXEMPTION.  
 (2) REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (2 Months - 5th Birthday Only)  
 (3) REQUIRED FOR K-GRADE 1 (whichever is first). GRADE 6 BEGINNING 9-1-01, AND GRADES 9-12, EFFECTIVE 9-1-04.  
 (4) REQUIRED FOR DAY/CHILD CARE ENROLLEES (19 Months and older) AND GRADE K-GRADE 1 (whichever is first) EFFECTIVE 9-1-04.  
 (5) MMR single antigen receipt requires MO/DAY/YR, serologies require titers, and varicella disease history requires MO/YR.  
 (6) REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (6 Months - 59 Months)

**HASBROUCK HEIGHTS PUBLIC SCHOOLS**  
**SCHOOL HEALTH SERVICES**  
**Hasbrouck Heights, New Jersey 07604**

**Dental Visit Form**

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_

Class/Grade: \_\_\_\_\_

The above named student was seen in this office on \_\_\_\_\_

for a dental exam. His/her teeth are:

\_\_\_ In good health

\_\_\_ In need of further treatment

\_\_\_\_\_

Dentist's signature

\_\_\_\_\_

Telephone Number

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Address or stamp

# HASBROUCK HEIGHTS PUBLIC SCHOOLS SCHOOL HEALTH SERVICES

## Health History Questionnaire

To the parents or guardians of \_\_\_\_\_

It is important we have this information for your child's well-being during his/her school hours. Please complete and return this form to the School Nurse as soon as possible.

1. Does he/she have a medical Problem? If yes, please state problem:

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2. Is he/she on medication? If yes, please list medication(s):

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3. Are there any restrictions? If yes, please list restrictions:

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4. Does your child have any allergies to food or medication? If yes, what:

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This information will be shared with staff as necessary. If you DO NOT want this information shared, please notify me immediately. Thank you for your cooperation in this matter.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(PARENT)

# Hasbrouck Heights Public School School Health Services

## AUTHORIZATION

### FOR THE EXCHANGE OF CONFIDENTIAL INFORMATION

STUDENT \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

As the parent/guardian of the above named student, I hereby authorize the release of pertinent medical information (medical conditions, allergies, medications and treatment regimes) to be exchanged among appropriate professional staff involved in the care of the above named student.

This consent is valid while your child attends school in the Hasbrouck Heights Public School and is intended to allow the staff to better serve your child. If you have any questions or concerns, please contact my office at the telephone number noted above.

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Parent / Guardian

\_\_\_\_\_  
Telephone Number

Thank you,

The Nursing Department  
Hasbrouck Heights Public School