TIMOTHY CHRISTIAN SCHOOL
2008 Ethel Road
Piscataway, NJ 08854
Main Office Phone: 732-985-0300 Main Office Fax: 732-985-8008 Nurses' Office Fax: 732-248-4271

IMMUNIZATION RECORD/PHYSICAL EXAMINATION FORM FOR GRADES Pre K4 - 5

Name of Student_____ Date of Birth_____ Grade_____

Address_____ City_____ State_____ Zip_____ Phone #_____

IMMUNIZATION DATES

D.P.T.

1st _____ 4th _____
2nd _____ 5th _____
3rd _____ Td _____
Tdap _____

POLIO VACCINE (Indicate OPV or IPV)

1st _____
2nd _____
3rd _____
4th _____

MMR

1st _____
2nd _____
VARICELLA_____
MENINGOCOCCAL_____
PNEUMOCOCCAL_____
INFLUENZA_____

HEP.B

_____
_____
_____

HIB

_____
_____
_____

MANTOUX

Date _____
Results _____

OTHER VACCINES _____
_____

Height _____ Weight _____ BP _____

Significant illnesses, accidents, congenital defects, allergies, etc.: _____

Significant factors in family situation or family history: _____

Please examine the following and indicate findings as normal or abnormal:

	Normal	Abnormal		Normal	Abnormal
Skin	_____	_____	Hernia	_____	_____
Eyes	_____	_____	Posture	_____	_____
Ears	_____	_____	Scoliosis	_____	_____
Nose/Throat/Mouth	_____	_____	Extremities	_____	_____
Glands	_____	_____	Genito-urinary	_____	_____
Heart	_____	_____	Nutritional Status	_____	_____
Lungs	_____	_____	Neurological	_____	_____
Abdomen	_____	_____	Balance & Coordination	_____	_____

If Abnormal, Treatment Advised: _____

Current Medications: _____

Please specify medical recommendations to school for academic and activity program.

Date: _____ Signature of Examiner: _____ Phone: _____

Address: _____

NOTE: ANY MEDICATIONS – OTC or RX – TO BE GIVEN IN SCHOOL MUST HAVE WRITTEN M.D. NOTE AND PARENT NOTE REWRITTEN FOR EACH SCHOOL YEAR