East Brunswick Public Schools
East Brunswick, New Jersey 08816
Student Services

Health Appraisal Form

Student Name: _____ Date of Birth: _____

School: _____ Date: _____

School Address: _____

Dear Parents:

Please present this form to your physician at the time of your child's examination. Upon completion, return to the school nurse at the school's address given above. Thank you.

Height: ____ Weight: _____B.P.:_____ Pulse: _____ Urine-Protein: _____ Sugar: _____

Vision-Right: _____Left: _____Both: _____ Glasses-Right: _____ Left: _____ Both: _____

Physical Findings	Please indicate with a √ (check) In the appropriate column. Normal	Abnormal	Specify and Recommend
EYES			
VISION			
COLOR PERCEPTION			
EARS - OTOSCOPIC			
HEARING			
Left			
Right			
TEETH/MOUTH			
NOSE			
THROAT			
LYMPH GLANDS			
THYROID			
HEART			
LUNGS			
ABDOMEN			
HERNIA			
GENITO-URINARY			
ORTHOPEDIC (STRUCTURAL)			
SCOLIOSIS SCREENING			
SKIN			
NUTRITION			
NERVOUS SYSTEM			
SPEECH			
OTHER			
GENERAL APPEARANCE			

Health Appraisal Form

Student Name: _____

DATE OF MOST RECENT MANTOUX TUBERCULIN:
TEST: _____ RESULT: _____ FOLLOW-UP: _____

COMPLETE IMMUNIZATION HISTORY (OR ATTACH COPY)

DPT/DTaP					
Tdap (Grade 6)					
Polio					
MMR					
Measles (on or after 1st birthday)					
Mumps (on or after 1st birthday)					
Rubella (on or after 1st birthday)					
Hib (after 1st birthday)					
Hepatitis B					
Varicella (on or after 1st birthday)					
Meningococcal (Grade 6)					
Pneumococcal (Pre-School) (after 1st birthday)					
Influenza (Pre-School)					

PLEASE LIST ANY HEALTH PROBLEMS WHICH MIGHT INTERFERE WITH THE STUDENT'S EDUCATIONAL PROGRAM OR LIMIT HIS/HER PARTICIPATION IN THE REGULAR PHYSICAL EDUCATION PROGRAM:

INDICATE ANY RESTRICTIONS:

COMMENTS:

DATE OF EXAMINATION: _____

SIGNATURE OF PHYSICIAN: _____

PRINTED NAME, ADDRESS AND TELEPHONE: _____
_____
_____
_____