SCHOOL HEALTH APPRAISAL **HR _____**

973-635-1700 **ECLC of NEW JERSEY** **Fax 973-635-2845**

PARENT **Please complete this portion:** RETURNING_____NEW_____

STUDENT'S NAME_____ BIRTHDATE___/____/____ AGE_____

HOME ADDRESS_____/_____/____ /_____
(street) (town) (state) (zip)

NAME OF PARENTS (or Guardian)_____

HOME PHONE _____ FATHER'S WORK PHONE_____

CELL PHONE _____ MOTHER'S WORK PHONE_____

FAMILY E-MAIL ADDRESS_____

PRIMARY PHYSICIAN_____PHONE _____

DENTIST_____PHONE_____

OTHER MD_____ SPECIALTY _____ PHONE_____

OTHER MD_____ SPECIALTY _____ PHONE_____

PHYSICIAN **Please complete this portion:**

GENERAL CONDITION:_____ DATE OF EXAMINATION: _____

VISION: R_____L_____DISTANCE_____ NEAR_____ GLASSES/CONTACTS:_____

HEIGHT: _____WEIGHT: _____B.P. _____ T_____P_____R_____

I. SKIN _____
NUTRITION_____
TEETH-MOUTH_____
POSTURE_____
FEET_____
GAIT_____

II. HEAD_____
EYES_____
EARS_____HEARING_____
NOSE-THROAT_____
TONSILS_____
ADENOIDS_____
NECK/THYROID_____
LYMPH NODES_____

III. HEART_____
LUNGS_____
ABDOMEN_____
GENITO-URINARY_____
TANNER STAGE _____
HERNIA_____

IV. MUSCLE-SKELETAL_____
EXTREMITIES_____
SPINE-CURVATURES_____

VI. NEUROLOGICAL (if indicated):_____
IS STUDENT SUBJECT TO SEIZURES?_____
WHAT TYPE?_____DATE OF LAST SEIZURE____/____/_____

DIAGNOSIS/DESCRIPTION OF ANY HEALTH OR PHYSICAL CONDITIONS:

1.
2.
3.
4.

IS THIS STUDENT ALLERGIC TO DRUGS, FOOD, INSECT BITES, ENVIRONMENT, ETC._____
IF YES EXPLAIN:_____
_____

DIET RESTRICTIONS: _____

ALL STUDENT MEDICATION(S): 1._____2._____3._____4._____
DOSAGE(S): 1._____2:_____3._____4._____
TIMES: (am/pm) 1._____2:_____3._____4:_____
PURPOSE: 1._____2._____3._____4._____

COMMUNICABLE DISEASES: (Disease/date): _____ ____/____/_____

IMMUNIZATIONS:

Tdap ____/____/_____ Meningococcal ____/_____/_____

MMR ____/____/_____ Seasonal Influenza Vaccine ____/_____/_____

Varicella ____/____/_____ **(vaccine date, disease date, or evidence of immunity required for work program)**

Two Step Tuberculosis (Mantoux) Test **REQUIRED FOR STUDENTS 17-21 YRS. IN WORK PROGRAM**

1) Placed _____Read _____Results_____ 2) Placed _____Read _____Results_____

DO YOU MEDICALLY CLEAR THIS STUDENT TO PARTICIPATE IN:

ALL STANDARD CLASSROOM ACTIVITIES	NO( )	YES( )
OFF CAMPUS WALKING TRIPS/FIELD TRIPS	NO( )	YES( )
ADAPTIVE PHYSICAL EDUCATION	NO( )	YES( )

IF NO, EXPLAIN:_____
_____

I HAVE EXAMINED THE ABOVE NAMED STUDENT AND FOUND HIM/HER PHYSICALLY FIT TO PARTICIPATE IN ALL SCHOOL ACTIVITIES (with restrictions noted).

PHYSICIAN'S NAME (Printed)_____

(Signature)_____
ADDRESS_____
PHONE_____DATE_____