Little Falls Township Public Schools
PRIVATE HEALTHCARE PROVIDER PHYSICAL EXAMINATION FORM

(To be completed by Private Healthcare Provider)

(Revised N.J.A.C. 6A: 16-2.2 & N.J.S.A. 18A: 40-4)

1. **Each student must be examined upon entry into the school district. The examination must be done no more than 1 year (365 days) before entry and must state what, if any, modifications are required for full participation in the school program.**
2. **Parents/guardians must be aware of the importance of obtaining subsequent examinations at least once during each of the student's developmental stages:**
   - **Early childhood (pre-school through grade 3)**
   - **Pre-adolescence (grades 4 through 6)**
   - **Adolescence (grades 7 through 12)**

Note to Healthcare Provider: **New Jersey students are to receive a current physical examination and recommendations from their healthcare provider, inclusive of a medical diagnosis and etiology for all physical and/or health impairments, prognosis, physical limitations, medications and description of prosthetic devices.**

STUDENT:_____ DOB_____ Grade_____ Date of this Exam_____

Please mark "N" for Normal or explain nature of finding.

Height_____ Weight_____ BMI_____

BP_____ Vision w/w-o Glasses_____ Nutrition_____

Eyes_____ Hearing_____ Scoliosis_____

Scoliosis_____ Skin/Scalp_____ Surgical HX_____

Throat_____ Respiratory System_____ Hx Hospitalizations_____

Asthma Hx_____ RAD_____ Exercise Induced_____

Chronic Health Conditions_____

Immunizations administered during today's visit_____

Does this student have any known allergies and/or allergic reactions? – No_____ Yes_____
(Please be specific) Student is allergic to:_____

Auto-injector of Epinephrine prescribed? No_____ Yes_____ (Rx must be attached)

Other Treatment of allergies:_____

Does this student have any physical or health impairment, syndrome, chronic illness or acute health condition which might limit strength, vitality or alertness or require adaptation of the educational program? If "Yes", please explain.

_____

Current medication: Does this student take any medication on a daily basis? No_____ Yes_____
If "Yes", list name, reason for prescription, dose frequency & possible side effects.

_____

_____ / _____ / _____ / _____

Health Care Provider's Name* Health Care Provider's Tel# Health Care Provider's Signature Date

Health Care Providers include: MD, Do, & Advanced Practice Nurse *Revised 08/2017*