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.

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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.

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______________ / ______________ / ______________ / ________

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