MONROE TOWNSHIP PUBLIC SCHOOLS
PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION
(TO BE RETURNED TO THE SCHOOL)

N-18b (rev. Nov. 06)

IMMUNIZATION REGISTRY NUMBER

Name of Child (Last, First, M.I.) | Date of Birth (Mo/Day/Yr) | Sex ☐ Male ☐ Female

PARENT OR GUARDIAN — NAME | TELEPHONE NO.
ADDRESS

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination * *(If Td or DT, indicate in corner box)*					
Tdap					
POLIO – INACTIVATED POLIO VACCINE (IPV) *If oral vaccine, indicate (OPV) in corner box*					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB)**					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE **					
MENINGOCOCCAL					
HEPATITIS A ***					
HPV (HUMAN PAPILLOMAVIRUS) ***					
OTHER					

LEAD SCREENING	
Test Date	Result

Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

☐ Provisional admission attached–Date Granted:_____ ☐ Medical exemption attached ☐ Religious exemption attached

	Date Given:	Date Read:	Results:
TB Testing:			

Note: The Mantoux text is the ONLY accepted method of testing according to N.J. AC 6.29-4.2

Has child been tested for lead poisoning? Yes / No If Yes, Give Date _____ What are the results? _____

Medical History: (Give significant details, including serious illness, allergies, operations, accidents, etc.)_____

Report of Examination: Ht._____ Wt._____ B/P_____ Visual Acuity_____

	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
EYES			HEART			POSTURE		
EARS			LUNGS			ORTHOPEDIC		
SKIN			ABDOMEN			REFLECTION		
NOSE & THROAT			SPINE			VISION		
TEETH			FEET			HEARING		
						HERNIA		

Explain abnormalities found _____

Is the child under treatment for any illness or abnormalities? YES _____ NO _____

If Yes explain _____

Is the child taking any medication? YES _____ NO _____
May the child participate in physical education activities and regular play? YES _____ NO _____
If NO, please specify restrictions_____

Signature of Physician	Address	Telephone	Date of Examination

Print Name of Physician_____