

**MILLBURN TOWNSHIP PUBLIC SCHOOLS
STUDENT HEALTH PROFILE**

Please have this form completed and signed by your child's pediatrician. This form is to be returned to the school office/school nurse. Kindergarten and PreK students must return this form before the first day of school. For New students, the completed form must be returned within one month of entry or the student will be removed from school. For students in grades 7 & 10, the completed form must be returned by November 1 of that school year.

Alternatively, you may attach this form to a printout from your doctor's office that includes a record of a recent physical examination and required immunizations.

Student Name _____		Gender M _____ F _____	
Birthdate ____/____/____ <small>(mm/dd/yyyy)</small>		School _____ Grade _____	
	NORMAL	ABNORMAL	EXPLAIN ABNORMALITIES
General			HT _____ WT _____ BP _____ Scoliosis _____
Speech			
Vision			Color Deficient? _____ Vision L: R: Both:
Hearing			Left: Right:
Glands			
Heart			Rate Murmur
Lungs			
Abdomen			
Hernia			
Genitalia			
Extremities			Gait
Other			
History of Illness or Surgery:			
Chronic Condition(s):			
Allergies:			
Medication(s):			
Conditions(s) which may affect the student's performance:			

IMMUNIZATION REQUIREMENTS

For **NEW STUDENTS**, & Students Entering **GRADES PRE-K, K, 7 & 10** -- Date of Immunization Must Include Month, Day, Year

D.P.T. SERIES	POLIO SERIES	HEPATITIS B SERIES
1 st :	1 st :	1 st :
2 nd :	2 nd :	2 nd :
3 rd :	3 rd :	3 rd :
4 th :	4 th :	
Booster:		Varivax: (1): (2):
Date:	M.M.R (1): M.M.R. (2):	
Date:	Measles	Influenza (PreK):
Haemophilus Influenza B	Mumps	Pneumococcal (PreK):
Date(s):	Rubella	Tdap (Gr. 6):
Other Vaccines:		Meningococcal (Gr. 6): (1): (2):

TUBERCULOSIS TESTING: N.J. requires that students from certain countries must have a Mantoux Test at the time of the physical examination. The school nurse will contact you if tuberculin testing is required.

Mantoux Test Date: _____ Result: _____ MM Report of Chest X-Ray _____ Date: _____

Physician's Signature _____ Exam Date: _____ Telephone: _____

PHYSICIAN'S STAMP