

Saint Peter School
415 Atlantic Avenue
Pt Pleasant Beach, NJ 08742
732-892-1260 www.stpschool.org

Required physical examination _____ *to be completed by child's physician*

Child's Name: _____

(Last) (First) (Middle)
Address _____ City _____ ZIP _____

Date of Birth _____ Male _____ Female _____

Father's Name: _____

Mother's Name: _____
(Maiden) _____

EXAMINATION

Weight _____ Height _____ Blood Pressure _____

Scoliosis _____

Vision R _____ L _____

Hearing R _____ L _____

IMMUNIZATIONS REQUIRED:

1.) DPT: 1 _____ 2 _____ 3 _____ 4 _____ Booster _____ Booster _____

2.) Polio (circle one) OPV/IPV

1 _____ 2 _____ 3 _____ Booster _____ Booster _____

3.) Live Measles Vaccine (Administered after the age of 1)

a.) MMR 1 _____ 2 _____

b.) Mumps _____

c.) Rubella _____

4.) H.I.B. 1 _____ 2 _____ 3 _____ 4 _____

5.) Hep B 1 _____ 2 _____ 3 _____

6.) Meningococcal _____

7.) Varicella _____ *or* DATE OF

DISEASE _____

Intradermal test for Tuberculosis

(Not required except for students born or transferring from a high TB incidence country)

Type _____ Date _____ Result _____

Treatment if positive _____

(over)

Allergies, Asthma, Illnesses, Operations, etc:

Physical Examination:

Positive Findings _____

Recommendations _____

May participate in competitive sports? _____

Limitation of activity: _____

Glasses needed for school work? _____

Hearing Loss? _____

Special Seating? _____

Date of Examination _____ Signature of Physician _____

Please **PRINT** Physician's name, address, and telephone

Physician's Name _____

Address _____ City _____ ZIP _____

Telephone _____