

TIMOTHY CHRISTIAN SCHOOL

2008 Ethel Road

Piscataway, NJ 08854

Phone: 732-985-0300

School Office Fax: 732-985-8008

Nurses' Office Fax: 732-248-4271

IMMUNIZATION RECORD/PHYSICAL EXAMINATION FORM

Name of Student _____ Date of Birth _____ Grade _____

Address _____ City _____ State _____ Zip _____ Phone # _____

IMMUNIZATION DATES

D.P.T.

1st _____ 4th _____
2nd _____ 5th _____
3rd _____ Td _____

POLIO VACCINE

(indicate OPV or IPV)

1st _____ 1st _____
2nd _____ 2nd _____
3rd _____
4th _____

MMR

VARICELLA _____

MENINGOCOCCAL _____

HEP.B

HIB

MANTOUX

PNEUMOCOCCAL _____

Date _____

INFLUENZA _____

mm Induration _____

OTHER VACCINES _____

Height _____ Weight _____ BP _____

Significant illnesses, accidents, congenital defects, allergies, etc.: _____

Significant factors in family situation or family history: _____

Please examine the following and indicate findings as normal or abnormal:

_____ Skin	_____ Glands	_____ Posture
_____ Eyes	_____ Heart	_____ Scoliosis Check
_____ Ears	_____ Lungs	_____ Extremities
_____ Nose & Throat	_____ Abdomen	_____ Genito-urinary
_____ Mouth	_____ Hernia	_____ Nutritional Status

Description:

Treatment Advised:

Current Medications: _____

Please specify medical recommendations to school for academic and activity program. (Please use other side.)

Date: _____ Signature of Examiner: _____ Phone: _____

Address: _____

NOTE: ANY MEDICATIONS – OTC OR RX – TO BE GIVEN IN SCHOOL MUST HAVE WRITTEN M.D. NOTE AND PARENT NOTE REWRITTEN FOR EACH SCHOOL YEAR.