



# Riverdale

## Public School District

52 Newark-Pompton Turnpike  
Riverdale, NJ 07457 Phone:  
973-839-1300  
FAX: 973-839-1024  
<http://www.rpsnj.org>

### Student Medical Examination (to be completed by a licensed health provider)

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ ☐ Female  
Home Address: \_\_\_\_\_ ☐ Male  
School: \_\_\_\_\_ Grade: \_\_\_\_\_

**Growth and Development:** Normal Premature Term  
Complications  
Early illness or injury

#### Systems Review:

Height	Weight	BMI	Glasses/Contact	Blood Pressure
Vision: R	L	B	S	
Audio: R	L	EEN T		Speech
Integument	Head & Neck			Lymphatic
Respiratory	Cardiovascular			Abdomen
Gastrointestinal	Genitourinary			Urinalysis
Musculoskeletal	Hernia			Scoliosis
Nervous	Emotional Symptoms			Nutrition

#### Neurological/Psychological:

#### General Assessment:

**Remarks** (Please list any special needs and/or medication required.):

#### Medical History:

	Year	Year	Year	Year
Allergies	Asthma	Otitis Media	Operations/Injuries	
Drug Sensitivities	Chicken Pox	Rheumatic Fever		
Lyme Disease	Seizure Disorder	Strep Infections	Hospitalizations	
Hepatitis	Diabetes	Mononucleosis		
Neuromuscular Disease	Heart Disease	Other	Congenital Defects	



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### Immunization History: (to be completed by a licensed health provider)

**DTaP:** 1. mm/dd/yy 2. mm/dd/yy 3. mm/dd/yy 4. mm/dd/yy 5. mm/dd/yy *Booster*

**Tdap:**  
(for students born after January 1997 and students entering Grade 6) *Booster*

**Polio IPV:** 1. mm/dd/yy 2. mm/dd/yy 3. mm/dd/yy 4. mm/dd/yy 5. mm/dd/yy

**OPV:** 1. mm/dd/yy 2. mm/dd/yy 3. mm/dd/yy 4. mm/dd/yy 5. mm/dd/yy

**MMR:** 1. mm/dd/yy 2. mm/dd/yy 3. mm/dd/yy

**Measles:** 1. mm/dd/yy 2. mm/dd/yy

**Mumps:** 1. mm/dd/yy 2. mm/dd/yy **Varicella Zoster:** 1. mm/dd/yy 2. mm/dd/yy

**Rubella:** 1. mm/dd/yy 2. mm/dd/yy

**HIB Vaccine:** 1. mm/dd/yy 2. mm/dd/yy 3. mm/dd/yy 4. mm/dd/yy 5. mm/dd/yy

**Hepatitis A Vaccine:** 1. mm/dd/yy 2. mm/dd/yy

**Hepatitis B Vaccine:** 1. mm/dd/yy 2. mm/dd/yy 3. mm/dd/yy

**PPD Mantoux:** Date Tested: Date Read: Results:

**Lead Test:** Date Tested: Lead Level:

**Influenza Vaccine:** 1. mm/dd/yy 2. mm/dd/yy 3. mm/dd/yy 4. mm/dd/yy  
(mandatory for pre-school students)

**Pneumococcal Vaccine:** 1. mm/dd/yy  
(mandatory for pre-school students)

**Meningococcal Vaccine:** 1. mm/dd/yy 2. mm/dd/yy 3. mm/dd/yy  
(mandatory for incoming Grade 6 students)

**Other  
(specify):**

Date of Examination: Physician's Signature:

Physician's Name (*please print*)

Office Address

Office Phone



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### Student Health Information Release Form (to be completed by a the parent/guardian)

**Parents/Guardians:** If your child has a history of allergies, takes medication, wears eyeglasses/contacts or has any health related concerns, it is important to give that information to the school nurse. The Family Education Rights and Privacy Act (FERPA) has issued regulations which require public schools to obtain written consent to disclose medical information. All information will be held in confidence by the school nurse and will be shared only with other school professionals as necessary. If you have any concerns or question, please do not hesitate to contact the school health office.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Grade: \_\_\_\_\_

Check one (if yes, please specify):

☐ ☐

Allergies

Yes No (If an EpiPen injection is necessary, a "permission to dispense" form must be submitted every school year.)

☐ ☐

Asthma

Yes No (If an inhaler is necessary, a "permission to dispense" form must be submitted every school year.)

☐ ☐

Hearing Difficulties

Yes No

☐ ☐

Vision Difficulties

Yes No

☐ ☐

☐ Eyeglasses ☐ Contact Lenses ☐ Other:

Seizure Disorder

Yes No

☐ ☐

Orthopedic

Difficulties/Walking

Yes No

☐ ☐

Aides

Medications (list condition and dosage)

Yes No

☐ ☐

Other pertinent information (including hospitalizations within the last year):

**I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.**

Parent Signature

Parent Name

Date