



EASTERN CHRISTIAN SCHOOL

Directions for Completing Physical Forms

Welcome to Eastern Christian School! To assist you in preparing for your child's entrance into school, we have prepared a checklist of requirements that need to be met. Please note the highlighted deadlines for each form.

- ___ **New Student Physical:** Due on or before the first day of school. A copy of an exam not more than 365 days prior to entrance is acceptable.
- ___ **Immunizations** must be complete and verified on the physical form.
- ___ **Mantoux TB Test:** All students entering Eastern Christian School from another country must have proof of Mantoux test.

| <u>Preschool (PK3, PK4, TK)</u> | <u>Kindergarten - Grade 5</u> | <u>Grades 6-12</u> |
|---|--|---|
| ___ 4 DPT ___ 3 Polio ___ 1 Influenza (Given between August & December of current school year. Children 6 months through 59 months attending a child care center) <i>The vaccines listed below should be given on or after the child's 1st birthday:</i> ___ 1 MMR ___ 1 HIB ___ 1 Pneumococcal ___ 1 Varicella (or proof of the disease immunity) | ___ 4 DPT (1 dose given on or after 4 th birthday or 5 doses) ___ 3 Polio (1 dose given on or after 4 th birthday or any 4 doses) ___ 2 MMR (On or after 1 st birthday) ___ 3 Hepatitis B ___ 1 Varicella (Given on or after 1 st birthday or proof of the disease immunity) | ___ 3 DPT (boosters recommended every 10 years) ___ 3 Polio ___ 2 MMR ___ 3 Hepatitis B ___ 1 Varicella ___ 1 Type ACYW Meningococcal (Students Age 11 or over) ___ 1 Tdap (Students Age 11 or older) |

- ___ **Inhaler/Asthma Forms:** If your child carries an inhaler, please have the doctor complete the **Asthma** forms, which can be found in "Resources" on the parent portal at www.easternchristian.org/portal (or portal link under "Parents" on the EC website). The Asthma form can also be obtained from your school nurse.
- ___ **Medication Form:** If your child requires any medication during school hours, please have the doctor complete the **Medication Administration in School** form, which can be found in "Resources" on the parent portal at www.easternchristian.org/portal (or portal link under "Parents" on the EC website). The medication form can also be obtained from your school nurse.
- ___ **Administration of Epinephrine Forms:** If your child requires an epi-pen at school, please have the doctor complete the **Epinephrine** forms, which can be found in "Resources" on the parent portal at www.easternchristian.org/portal (or portal link under "Parents" on the EC website). The Epinephrine form can also be obtained from your school nurse.
- ___ **Sports Forms:** If your child is participating in a sport during the school year, please have the physician complete the **PPE Sports Physical** forms, which can be found in "Resources" on the parent portal at www.easternchristian.org/portal.
If your child is participating in a High School fall sport, please register your child for sports www.easternchristian.org click on "Athletics" and then "Athletic Information Hub" and then "Register Here" to create an account and register. Sports forms are due by August 1 and can be emailed to Diane DeRooy RN at: hsnurse@easternchristian.org If your child is participating in a Middle School fall sport, forms are due by August 15 and can be emailed to the MS nurse at: msnurse@easternchristian.org.

Completed forms can be emailed to the school nurse for the campus your child attends:

EC Preschool and Elementary School
Midland Park, NJ
esnurse@easternchristian.org

EC Upper Elementary & Middle School
Wyckoff, NJ
msnurse@easternchristian.org

EC High School
North Haledon, NJ
hsnurse@easternchristian.org



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PHYSICAL EXAMINATION REPORT (Due before the first day of entrance to school)

Student's Name: _____ Phone: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip)

Date of Birth: _____ Sex: _____ Grade Level in September: _____

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

New Student from: _____
(School) (City) (State)

Student's Medical History

(To be completed by Parent and Reviewed by Physician)

| | YES | NO | Description/Reason |
|---------------------------------------|-----|----|--------------------|
| Allergies | | | |
| Asthma | | | |
| Blood Disorders | | | |
| Cancer | | | |
| Chicken Pox | | | |
| Diabetes | | | |
| Headaches | | | |
| Hearing Problems/Hearing Aide | | | |
| Heart Disease | | | |
| Anxiety/Depression | | | |
| High/Low Blood Pressure | | | |
| Hospitalizations | | | |
| Kidney/Urinary Tract Problem | | | |
| Medication Reactions | | | |
| Menstrual Disorder | | | |
| Mononucleosis | | | |
| Muscular Disorder | | | |
| Orthopedic Disorder | | | |
| Rheumatic Fever | | | |
| Scoliosis | | | |
| Seizure Disorder | | | |
| Strep Infections | | | |
| Surgery | | | |
| Ulcer/Gastrointestinal Disorder | | | |
| Visual Problem/Glasses/Contact Lenses | | | |
| Other | | | |

Does the student take any regular medication? Please name medication and dosage: _____

Has the student ever been advised by a physician not to play a sport? _____

Are there any other physical or emotional conditions that might affect this child's abilities or performance? _____

TO BE COMPLETED BY PHYSICIAN *Please also review front page medical history*

Student's Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision without Correction: R20/ _____ L20/ _____ Both 20/ _____

Vision with Correction: R20/ _____ L20/ _____ Both 20/ _____

Hearing: Right: _____ Left: _____

Nutrition (Please note significant weight gain or loss in the last year): _____

Head & Neck: _____ Lungs: _____ Extremities: _____

Nose: _____ Heart: _____ Neurological: _____

Eyes: _____ Abdomen: _____ Urinalysis: _____

Ears: _____ Back: _____ Hemoglobin: _____

Throat: _____ Genitalia: _____ Scoliosis Screening: _____

Chest/Breast: _____ Hernia: _____ If positive, Treatment? _____

Comments: _____

• **Based on this history/physical, this student:**

_____ may participate in physical education activities.

_____ has health problems, which prohibit participation in the following activities: _____

A. **New Students:** Complete information for all immunizations must be submitted. Please include month, day and year for each immunization.
Returning Students: Please note date of last booster and any other immunization that has been given in the last year.

| VACCINE TYPE | 1 ST Dose Mo/Day/Yr | 2 ND Dose Mo/Day/Yr | 3 RD Dose Mo/Day/Hr | 4 TH Dose Mo/Day/Yr | 5 TH Dose Mo/Day/Yr | LEAD SCREENING | |
|---|---|-----------------------------------|-----------------------------------|--|-----------------------------------|--|--------------------------|
| Diphtheria, Tetanus, Pertussis – (DTaP) <small>*If Td or DT, write in corner box</small> | | | | | | | |
| Tdap (not Td) | | | | | | | |
| Polio-Inactivated Vaccine (IPV) <small>If oral polio, write (OPV) in corner box</small> | | | | | | | |
| MMR (Measles, Mumps & Rubella) | | | | | | Document below single antigen vaccine receipt, serology titers, or varicella disease history | |
| Haemophilus B (HIB)** | | | | | | Hepatitis B | Date: _____ Titer: _____ |
| Hepatitis B | | | | | | Varicella | Date: _____ Titer: _____ |
| Varicella | | | | | | Measles | Date: _____ Titer: _____ |
| Pneumococcal Conjugate** | | | | | | Mumps | Date: _____ Titer: _____ |
| Meningococcal (Meningitis (ACYW)) | | | | | | Rubella | Date: _____ Titer: _____ |
| Hepatitis A*** | | | | | | | |
| Influenza** | | | | | | | |
| HPV (Human Papillomavirus)** | | | | | | | |
| Other (Specify) | | | | | | | |
| *DT Requires valid medical exemption **Required for Day/Child Care (2m-5yo) | Medical exemption attached <input type="checkbox"/> *** Not Required | | | Religious exemption attached <input type="checkbox"/> Provisional admissions attached <input type="checkbox"/> Date Granted: _____ | | | |

B. **Mantoux Tuberculin Test:** Date: _____ Result: _____ If positive, did student have chest X-ray? _____ Result? _____

Physician's Signature: _____ Date of Examination: _____

Physician's Name: _____ Address: _____

Phone Number: _____