Hanover Township Public Schools
Pre-Entrance Physical Examination Form To Be Completed
By Family Physician

Name: _____ D.O.B.: _____ Physician: _____
Address: _____

Weight: _____ Height: _____ BP: _____
Vision: (R): _____ (L): _____ Disease: _____
Audio: (R): _____ (L): _____ Disease: _____

Heart: _____ Lungs: _____ Abdomen: _____
Skin: _____ Scalp: _____ Mouth/Teeth: _____
Orthopedic: (Structure) _____ (Posture) _____ (Feet) _____
Glands: _____ Thyroid: _____ Nasal Passages: _____ Throat: _____
Teeth: _____ Hernia: _____ Genito-Urinary: _____
Allergies: _____ Surgeries: _____
Abnormalities: _____

Disease History:

Asthma: _____ Mumps: _____ Chicken Pox: _____ Polio: _____ Hepatitis: _____
German Measles: _____ Pneumonia: _____ Meningitis: _____ Mononucleosis: _____
Scarlet Fever: _____ Lyme Disease: _____ Diabetes: _____ Otitis Media: _____
Congenital Defects: _____ Convulsive Disorders: _____
Neuromuscular Disorders: _____ Heart Disease: _____ Strep: _____
Other: _____
Recommendations/Limitations: _____

_____ _____
Date of physical **Signature of MD (No Stamp)**

Immunization Requirements: List month/day/year

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	LEAD SCREENING	
						Test Date	Result
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination * *(If Td or DT, indicate in corner box)*							
Tdap							
POLIO – INACTIVATED POLIO VACCINE (IPV) *If oral vaccine, indicate (OPV) in corner box*							
MEASLES, MUMPS, RUBELLA (MMR)							
HAEMOPHILUS B (HIB)**							
HEPATITIS B							
VARICELLA							
PNEUMOCOCCAL CONJUGATE **							
MENINGOCOCCAL							
HEPATITIS A ***							
HPV (HUMAN PAPILLOMAVIRUS) ***							
OTHER							

Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

☐ Provisional admission attached-Date Granted: _____ ☐ Medical exemption attached ☐ Religious exemption attached

Mantoux Test Date: _____ Read Date: _____ Results: _____
(Office immunization form may be attached)

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