ST. AUGUSTINE OF CANTERBURY SCHOOL
45 HENDERSON ROAD
KENDALL PARK, NEW JERSEY 08824
(732) 297-6042 Fax (732) 297-7062

MEDICAL EXAMINATION OF STUDENT BY PRIVATE PHYSICIAN
(Please Print)

Student's Name: _____ Date of Exam: _____
Physician: _____ Phone #: _____

Immunization(s) and/or test(s) given on this date: _____
_____
Significant Factors in Home Situation: _____
_____

Please indicate below by check, any positive findings and describe fully in the section on the right.

Exam		Description	Treatment Advised
Skin			
Eyes			
Ears			
Nose & Throat			
Mouth			
Glands			
Heart			
Lungs			
Abdomen			
Hernia			
Orthopedic			
Genito-Urinary			
Nutrition			
Other			

Vision (if done) R: _____ L: _____ Height: _____
Hearing (if done) R: _____ R: _____ Weight: _____
Blood Pressure _____ Scoliosis: Negative_____
Positive _____

Student may have age/weight appropriate dosage of Tylenol for occasional headache without fever. Parents are informed of time administered. Yes ____ No _____

Specify medical recommendations to School for academic and activity programs (use additional paper if necessary).

Examining Physician: _____ License #: _____
Address: _____ Phone #: _____

Immunization Record on back of page. Please have your physician complete this portion

Immunization Record

Name:_____ Date of Birth:_____

Vaccine ***Date Given***

DTaP or DT #1_____ Booster _____

#2_____ Booster _____

#3_____

Tdap (Adacel
Or Boostrix) Booster_____

IPV or OPV #1_____ Booster _____

#2_____

#3_____

Hepatitis B #1_____ #2_____ #3_____
or Hib/Hep

HIB #1_____ #2_____ #3_____

#4_____

MMR #1_____ #2_____

Varicella #1_____ #2_____

Pnuemo-7 #1_____ #2_____ #3_____

#4_____

Hepatitis A #1_____ #2_____

Flu _____ _____ _____ _____

_____ _____ _____ _____

Meningococcal (Mennomune or Menactra)_____

HPV #1_____ #2_____ #3_____

Mantoux Test: _____ _____

Other _____ _____ _____