BERGEN COUNTY REGION III MEDICAL FORM

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HAEMOPHILUS B (HIB)	
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REPORT OF MEDICAL EXAMINATION To Be Completed by Physician: Eyes _____ Extremities ____ Heart _____ Ears Lungs _____ Abdomen Nose ____ Skin ____ Other ____ Hernia _____ Nervous System _____ Throat _____ Orthopedic _____ Scoliosis ____ Laboratory: GLUCOSE _____ Urine _____ ALB ____ Hemoglobin _____ Other Tests Special Tests (EEG, EKG, Radiology, etc.) Test: _____ Date: ____ Findings: Please attach copies of consultant's findings. Is there a history of convulsions or seizures? If yes, please explain Yes ______ No _____ **Present Medications** Dosage **Dated Started** Is medication required during school hours? Yes _____ No ____ Future therapy or tests planned: When should this child be examined again? Diagnostic impressions: Summary of health findings which would have an effect on the pupil's learning processes and any care or restrictions with regard to health, safety, and physical education. (If no specific medical problems or restrictions exist, please indicate.) Physician's signature: Please print or stamp Physician's name: Address: Date: Phone number:

PLEASE COMPLETE ALL APPLICABLE INFORMATION AND RETURN TO:

Hillside Elementary School CST 340 Homans Avenue Closter, NJ 07624

Closiel, NJ 0/024

ATTN: Kristen Haenelt, RN