

**CRANFORD PUBLIC SCHOOLS
Cranford, NJ**

MEDICAL ENROLLMENT FORM

Name: _____ Date of Birth : _____ Gender: M ___ F ___

Health Information (to be completed by parents)

Asthma _____ Eczema _____ Meningitis _____ Other _____

Cardiac _____ Hepatitis _____ Pneumonia _____ Lyme _____

Chicken Pox _____ Immune Disorder _____ Rheumatic Fever _____

Bronchitis _____ Tuberculosis _____ Seizure Disorder _____ Other _____

Allergies (describe) _____

Other: (operations, serious injuries, convulsions etc) _____

List any relevant disability _____

Indicate any vision or hearing difficulty _____

List any medications _____

THIS SECTION TO BE COMPLETED BY THE FAMILY PHYSICIAN ONLY

Immunizations:

1.	DPT	_____	_____	_____	_____	_____
		Date	Date	Date	Date	Date
2.	Polio	_____	_____	_____	_____	
		Date	Date	Date	Date	
3.	MMR	_____	_____			
		Date	Date			

OR

Measles Vaccine	_____	_____
	Date	Date
Mumps	_____	
	Date	
Rubella	_____	

Name _____

4. Hib Vaccine _____
Date Date Date Date

5. Chickenpox Vaccine _____
Date

6. Hepatitis B Vaccine _____
Date Date Date

7. Influenza Vaccine* _____ Pneumococcal Vaccine* _____
Date Date

8. Meningococcal Vaccine ** _____ Tdap Vaccine** _____
Date Date

**For Pre-School Students only ** For grade 6 students and/or transfer students from out of state/country*

Mantoux Test _____
Date Results

BCG _____
Date

Physical Examination

Vision: R _____ L _____ Corrected : Y _____ N _____
Glasses: Y _____ N _____
Contact Lenses: Y _____ N _____
Hearing: R _____ L _____

Height _____ Weight _____ BP _____
Eyes _____ Ears _____ Skin _____
Heart _____ Lungs _____ Thyroid _____
Tonsils and Adenoids _____ Hernia _____ Genitals _____

Other Glands _____

General Physical Condition _____

Signature of Physician

Date of Examination
(within 365 days of the 1st day of school)

Health Records Checked by _____ Date _____