CRANFORD PUBLIC SCHOOLS
Cranford, NJ

MEDICAL ENROLLMENT FORM

Name:_____ Date of birth:_____ Gender: M___ F___

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 Vaccine _____
Date

Rubella Vaccine _____
Date

4. Varicella (Chicken Pox) Vaccine _____
   Date

5. Hepatitis B Vaccine _____ _____ _____
   Date Date Date

** Pre-School Students ** Grade 6 students and grade 6 or above transferring from out of state/ country*

6. Hib Vaccine* _____ _____ _____ _____
   Date Date Date Date

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

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

For students entering school system from High Incidence TB Country

Mantoux Test _____ Results_____ BCG _____
Date Date

Physical Examination **(***must be within 365 days of the first day of school)*

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 Exam
(*within 365 days of 1st day of school)*

To be signed by school employee

Health Records Checked by_____ Date_____

Rev 10/2011