

**PRINCETON DAY SCHOOL**  
**HEALTH RECORD AND EMERGENCY TREATMENT FORM**

Phone: (609)924-6700 Fax: (609)924-4230

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_  
Parents/Guardians: \_\_\_\_\_  
MOTHER: Phone (h) \_\_\_\_\_ Phone (w) \_\_\_\_\_ Cell \_\_\_\_\_  
FATHER: Phone (h) \_\_\_\_\_ Phone (w) \_\_\_\_\_ Cell \_\_\_\_\_  
Local Emergency Contact (if parent cannot be reached): Name \_\_\_\_\_ Phone \_\_\_\_\_

Permission for child to receive Tylenol/Advil from school nurse: Yes \_\_\_ No \_\_\_

Authorization for treatment if parent cannot be reached: Yes \_\_\_ No \_\_\_

I give permission for the school nurse to share information concerning my child's health to those faculty/staff members on a "need to know" basis. I recognize that sharing this information is important to my child's well-being.

**Parent's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Health History**

List Current Medical Issues (ie. Asthma, Diabetes, Illnesses) \_\_\_\_\_

Significant Past Medical History (ie. Surgeries, Illnesses, Injuries): \_\_\_\_\_

History of concussion? Yes \_\_\_ No \_\_\_ (if yes, when \_\_\_\_\_)

Females only: Age menstruation started: \_\_\_\_\_

List Daily Medications: \_\_\_\_\_

List all allergies: \_\_\_\_\_ Is an epi-pen required for allergies? \_\_\_ Yes \_\_\_ No

**ANNUAL PHYSICAL to be completed by physician**  
**(An annual physical is required of each student)**

**Date of Examination:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ lbs. **B/P** \_\_\_\_\_ **Pulse** \_\_\_\_\_

**Vision Acuity: Contacts: Y/N Glasses: Y/N**

Right 20/ \_\_\_\_\_

Corrected to 20/ \_\_\_\_\_

Left 20/ \_\_\_\_\_

Corrected to 20/ \_\_\_\_\_

**Hearing: 20 db HL**

Right 500 \_\_\_ 1000 \_\_\_ 2000 \_\_\_ 4000 \_\_\_

Left 500 \_\_\_ 1000 \_\_\_ 2000 \_\_\_ 4000 \_\_\_

**N = Normal**

General	N	Lungs	N
Eyes	N	Abdomen	N
Ears	N	Hernia	Absent/NA
Nose	N	Skin	N
Throat	N	Neurologic	N
Teeth	N	Musculoskeletal	N
Neck	N	Scoliosis	Absent
Heart	N		
Murmur	Absent/Present		

Abnormal Findings: \_\_\_\_\_

Approved for full sports and physical education: Yes \_\_\_\_\_ No \_\_\_\_\_

Approved with the following restrictions: \_\_\_\_\_

Recommendations: \_\_\_\_\_

**PLEASE ATTACH A COPY OF NEW IMMUNIZATIONS**

**Physician Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

The school physician has received the medical report from the student's medical home and it complies with the requirements of N.J.A.C. 6A:16-2.2 (h)5; and further, that the school physician's notification regarding the student's participation in athletics and signature is based solely on the medical examination and results submitted by the examining physician.

School Physician's Initial/Stamp: \_\_\_\_\_ Date \_\_\_\_\_