



# Hopatcong Borough Schools

Mr. Art DiBenedetto  
*Superintendent of Schools*

Learning Today. Leading Tomorrow.

---

## Kindergarten Students

Dear Parents,

The following items are required in order for kindergarten students to start school in September.

1. Recent Physical Exam that has been performed within the last year
2. Copy of child's immunization record
3. All immunizations must be up-to-date
  - DTaP-a total of 4 doses with one of these doses on or after the 4<sup>th</sup> birthday or  
Any 5 doses
  - Polio- a total of 3 doses with one of these doses given on or after the 5<sup>th</sup> birthday  
or any 4 doses.
  - MMR – 2 doses
  - Varicella – 1 dose
  - Hepatitis B – 3 doses

A copy of the Student Physical for Hopatcong School District is attached.

## Student Physical Hopatcong School District

<b>Name:</b>	<b>Date of Physical Exam:</b>
<b>Gender:</b> <b>Male</b> <b>Female</b>	<b>DOB:</b> <b>Age:</b>

PHYSICAL EXAM	NORMAL	IF ABNORMAL - COMMENTS
Skin and lymph nodes		
Eyes		
Ears		
Nose		
Throat		
Teeth and Gums		
Glands – cervical thyroid other		
Heart/Cardio		
Lungs/Respiratory		
Abdomen/GI		
Hernia		
Kidneys/Bladder/GU		
Neurologic/Developmental/Speech		
Orthopedic		

### MEDICAL CONDITIONS

<b>Chronic Medical Conditions</b>	<input type="checkbox"/> none	comments
Surgeries	<input type="checkbox"/> none	comments
Medications/Treatments	<input type="checkbox"/> none	comments
Allergies-Food or Medication	<input type="checkbox"/> none <input type="checkbox"/> care plan attached	comments
Emergency Plans (asthma, diabetic, seizures, Epinephrine)	<input type="checkbox"/> none <input type="checkbox"/> care plan attached	comments
Special diet/Vitamin & Mineral supplements	<input type="checkbox"/> none	comments
Behavior Issues/Mental Health Diagnosis	<input type="checkbox"/> none	comments

### PREVENTIVE HEALTH SCREENINGS

Type	Date Performed	Results	Type	Date Performed	Results
Hearing			Scoliosis		
Vision		Left eye	Right eye	Both eyes	
Height:		Weight:		B/P:	

TB (mm of induration) \_\_\_\_\_ date performed \_\_\_\_\_

Are there any other restrictions to child's activities or physical limitations? \_\_\_\_\_

*I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all school activities, including physical education and competitive contact sports, unless noted above.*

Health Care Provider Stamp

Name of Health Care Provider (print)

Signature/Date Form Signed