



VERNON TOWNSHIP SCHOOL DISTRICT  
 Cedar Mountain Primary School  
 P.O. Box 420, 17 Sammis Road, Vernon, NJ 07462  
 Phone: 973-764-2890 Fax: 973-764-3294 Web: [www.vtsd.com](http://www.vtsd.com)

Rosemary Gebhardt, Principal  
 rgebhardt@vtsd.com

**Medical Appraisal – Kindergarten**

Name \_\_\_\_\_ Birthday \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

To the Physician:

In order to provide a school program geared to meet the individual needs of each child, it is necessary to have a report of a physical examination. Please indicate your findings on this form.

**PHYSICAL FINDINGS:**

General nutrition	Throat	Genito-urinary
Eyes & eyelids	Teeth	Posture
Ears	Tonsils	Feet
Nose	Speech	Gait
Mouth	Abdomen	Lungs
Heart	Hernia	Skin

Please list any medications this child is taking: \_\_\_\_\_

Recommendations and comments:

DBT BOOSTER – dose administered after 4<sup>th</sup> birthday (Date) \_\_\_\_\_

POLIO BOOSTER – dose administered after 4<sup>th</sup> birthday (Date) \_\_\_\_\_

MMR – 2<sup>nd</sup> dose administered (Date) \_\_\_\_\_

Hep B – 3 doses      Date #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Varicella Vaccine Date \_\_\_\_\_ OR Varicella Disease Date \_\_\_\_\_

Physician Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Address \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Parental/ Guardian Consent:

Consent is hereby given for this record to be sent to Walnut Ridge School.

\_\_\_\_\_

Parent /Guardian Signature    Date

**REMINDER: All information is to be completed and returned to the school. Your child will not receive teacher or bus information until all forms are completed and returned**

