



## ST. CATHERINE OF SIENA SCHOOL

*Middle States Accredited*

39 E. Bradford Avenue, Cedar Grove, NJ 07009

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[www.scs-school-cedargrovenj.org](http://www.scs-school-cedargrovenj.org)

TO: Parents of NEW Students **Grades 6-8** and CURRENT Students **Grade 8**  
**NOT PLAYING SPORTS**

FROM: Mrs. Bethanie Sundlin, RN, BSN

RE: Pre-entrance physicals/completed immunizations



In order to enter St. Catherine of Siena School, all NEW students (Grades 6-8) must have **(1) a pre-entrance physical** and **(2) completed immunizations**. In accordance with the recommendation of the NJ Department of Education (N.J. A.C.6A:16-2- 2(d)1), we also recommend that **all current students in grades 8** also receive a physical examination.

For your convenience, I am listing the required immunizations on the back of this letter. **If your child(ren)'s immunizations are incomplete, your child will not be permitted to start school until they are completed.**

Please be sure the health examination form and immunization record are completed and **signed by your physician** with date of examination. ALL forms must be completed, signed and returned by June 1st. **Please remember that your child will not be permitted to enter school if all medical forms are not submitted.** If you have any questions, please feel free to call me at school.

***Participating in a sport? If yes, do not use this form. Please use the SPORT Health Forms (New Jersey Pre-participation questionnaire and physical forms). All Students in grades 6-8 who participate in school sponsored sports activities, are required to have yearly physical exams prior to the start of the sports season. All sports questionnaires and physicals must be returned before the first practice of the sport season. All physicals must be done using the New Jersey Pre-participation questionnaire and physical forms. No other physical forms will be accepted.***

## ST. CATHERINE OF SIENA SCHOOL PHYSICAL EXAMINATION

Name \_\_\_\_\_ \*Exam Date \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
 School \_\_\_\_\_ Sport \_\_\_\_\_ Grade \_\_\_\_\_ Sex \_\_\_\_\_  
 Physician \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**PHYSICIAN OR PROVIDER INFORMATION - PLEASE COMPLETE BOTH PAGES**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood pressure: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_ bpm  
 Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y/N Contacts: Y/N Glasses: Y/N

	Normal	Abnormal Findings	Comments
Head/Neck			
Eyes/Sclera/Pupils			
Ears/Hearing			
Nose/Mouth/Throat			
Heart: Murmurs/Rhythms			
Lungs: Auscultation/Perussion			
Chest Contour			
Skin			
Abdomen: Assessment(inc. liver, spleen)			
Tanner Stage: Testes/onset of menses			
Hernia	No	Yes/Possible	
Neck/Back/Spine: Range of motion			
Scoliosis			
Upper Extremities			
Lower Extremities			
Neurological: Balance & Coordination:			
Romberg			
Heel Walk			
Tandem Walk			
Nose Touch			
Toe Walk			
Most recent immunization/dates:			
Medications currently in use:			
Allergies:			
Operations or accidents:			

A. Student may participate in athletics: Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_

B. Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

C. **NOT CLEARED FOR:** Collision \_\_\_\_\_ Contact \_\_\_\_\_ Non-contact \_\_\_\_\_  
 Strenuous \_\_\_\_\_ Moderate \_\_\_\_\_ Non-strenuous \_\_\_\_\_

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

<p><b>Examined by: Family Physician/Provider</b> _____  <b>School Physician</b> _____                  _____ MD _____ DO _____ NP _____ PA</p> <p><b>*Physician/Provider Signature</b> _____</p>	<p><b>Physician's/Provider's Stamp:</b></p>
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