**SOUTH BRUNSWICK TOWNSHIP PUBLIC SCHOOLS**

**PHYSICAL EXAMINATION**

DATE OF EXAM\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SCHOOL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GRADE\_\_\_\_\_\_\_\_\_ TEACHER / UNIT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEIGHT\_\_\_\_\_\_\_\_\_\_\_\_\_ WEIGHT\_\_\_\_\_\_\_\_\_\_\_\_\_ BLOOD PRESSURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PULSE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EARS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEARING R\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_L\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EYES\_\_\_\_\_\_\_\_\_\_\_ VISION R 20/\_\_\_\_\_\_\_\_\_\_\_L 20/\_\_\_\_\_\_\_\_\_\_\_ WITH / WITHOUT CORRECTION (CIRCLE ONE)

NOSE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ THROAT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LYMPH GLANDS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ THYROID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TEETH / MOUTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEART\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LUNGS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ABDOMEN / HERNIA\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ORTHOPEDIC STRUCTURAL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SCOLIOSIS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FEET\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SKIN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NUTRITION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NERVOUS SYSTEM\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SPEECH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMMUNIZATIONS (MONTH - DAY - YEAR)**

**DTaP**  1\_\_\_\_\_\_\_\_\_\_\_\_ 2\_\_\_\_\_\_\_\_\_\_\_\_ 3\_\_\_\_\_\_\_\_\_\_\_\_ 4\_\_\_\_\_\_\_\_\_\_\_\_ 5\_\_\_\_\_\_\_\_\_\_\_\_

**Tdap** 1\_\_\_\_\_\_\_\_\_\_\_\_

**OPV / IPV** 1\_\_\_\_\_\_\_\_\_\_\_\_ 2\_\_\_\_\_\_\_\_\_\_\_\_ 3\_\_\_\_\_\_\_\_\_\_\_\_ 4\_\_\_\_\_\_\_\_\_\_\_\_ 5\_\_\_\_\_\_\_\_\_\_\_\_

**MMR**  1\_\_\_\_\_\_\_\_\_\_\_\_ 2\_\_\_\_\_\_\_\_\_\_\_\_

**HIB**  1\_\_\_\_\_\_\_\_\_\_\_\_ 2\_\_\_\_\_\_\_\_\_\_\_\_ 3\_\_\_\_\_\_\_\_\_\_\_\_

**HEPATITIS B** 1\_\_\_\_\_\_\_\_\_\_\_\_ 2\_\_\_\_\_\_\_\_\_\_\_\_ 3\_\_\_\_\_\_\_\_\_\_\_\_

**VARICELLA** 1\_\_\_\_\_\_\_\_\_\_\_\_ 2\_\_\_\_\_\_\_\_\_\_\_\_

**PCV** 1\_\_\_\_\_\_\_\_\_\_\_\_ 2\_\_\_\_\_\_\_\_\_\_\_\_

**MENINGITIS** 1\_\_\_\_\_\_\_\_\_\_\_\_

**FLU** 1\_\_\_\_\_\_\_\_\_\_\_\_ (Most Recent)

**MANTOUX** DATE\_\_\_\_\_\_\_\_\_\_\_\_\_ RESULT\_\_\_\_\_\_\_\_\_mm CHEST X-RAY\_\_\_\_\_\_\_\_\_\_\_\_\_ INH\_\_\_\_\_\_\_\_\_\_

**MOST RECENT LEAD LEVEL**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNIFICANT PAST MEDICAL/SURGICAL HISTORY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ANY CHRONIC ILLNESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST CURRENT MEDICATIONS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESTRICTIONS OR RECOMMENDATIONS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL PROVIDER’S SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL PROVIDER’S NAME, ADDRESS AND PHONE (PLEASE PRINT OR STAMP):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rev 6-4-12/BS