

**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 _____ 6 _____

OPV / IPV 1 _____ 2 _____ 3 _____ 4 _____

MMR 1 _____ 2 _____

HEPATITIS B 1 _____ 2 _____ 3 _____

HIB 1 _____ 2 _____ 3 _____

VARICELLA 1 _____ 2 _____

PCV 1 _____ 2 _____

FLU 1 _____ (Most Recent)

MENINGITIS 1 _____

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):
