BEVERLY CITY SCHOOL DISTRICT

Physical Examination Record

Grade_____

_____ _____ _____

Last Name First Birth date Phone

_____ _____

Parent/Guardian Address

_____ _____

Examining Provider Address

_____

IMMUNIZATIONS: Complete immunization record MUST be attached in order for this form to be valid.

If born outside of the USA, must have TB/Mantoux test if the country of origin is deemed to have a high risk of TB exposure by the NJ Department of Health.
(Mantoux test if applicable)

Tested on_____ **Read on**_____ **Result (mm)**_____

EXAMINATION:

Vision: R 20/_____ L 20/_____ Corrected Y/N

Hearing: R Pass/Fail L Pass/Fail **Presence of Scoliosis**: Y/N

Height:_____ Weight:_____ Blood Pressure:_____

Ears (otoscopic)_____ Nervous System_____

Eyes_____ Genitourinary_____

Lymphatic_____ Orthopedic_____

Thyroid_____ Skin_____

Nose_____ Hands_____

Throat_____ Feet_____

Teeth-mouth_____ Speech_____

Heart_____ General Appearance_____

Lungs_____ Other_____

_____

Abdomen_____ _____

CONTINUED

_____

PHYSICAL EXAMINATION RECORD

MEDICAL HISTORY

Allergies_____ Heart Disease_____

Congenital Conditions_____ Otitis Media_____

Drug Sensitivities_____ Strep Infections_____

Hepatitis_____ Mononucleosis_____

Neuromuscular_____ Oncologic Conditions_____

Asthma_____ Operations_____

Varicella History/Date_____ Fractures_____

Diabetes_____ Significant Injuries_____

Mental Health Conditions_____ Hospitalizations_____

_____

Other_____

_____

Medications_____

PROVIDER'S FINDINGS PERTINENT TO SCHOOL

Classification of Physical Activity_____

Full Academic Work Program_____

Follow-up and Notes_____

_____ _____

Signature of Physician/Provider Date of Exam

_____

Print Physician/Provider Name