

TEANECK PUBLIC SCHOOLS
School Health Services

Physical Examination

Student's name: _____ Age: _____ DOB: _____ Sex: _____
 Parent/Guardian name: _____ Address: _____
 Phone #: _____ School: _____ Grade: _____
 Health Care Provider: _____ Phone: _____ Fax: _____
 Address: _____ City/State/Zip: _____

PHYSICIAN / HEALTH CARE PROVIDER – PLEASE COMPLETE BOTH SIDES OF FORM

Exam Date: _____ Height: _____ Weight: _____ BP: _____ Pulse: _____
 Vision: R 20/ L 20/ Corrected: Y N Glasses: Y N Hearing: R _____ L _____

	Normal	Abnormal Findings	Comments
General Appearance			
Head/Neck			
Eye/Sclera/Pupils			
Ears:			
<i>Gross Hearing</i>			
Nose/Mouth/Throat			
Lymph Glands			
Heart:			
<i>Murmurs/Rhythms</i>			
Lungs:			
<i>Auscultation/Percussion</i>			
Chest Contour			
Skin			
Abdomen:			
<i>Assessment (inc. liver/spleen)</i>			
Tanner Stage:			
<i>Testes/Onset of Menses</i>			
Hernia			
Neck/Back/Spine:			
<i>Range of motion</i>			
Scoliosis			
Upper Extremities			
Lower Extremities			
Neurological:			
<i>Balance & Coordination</i>			
<i>Romberg</i>			
Evidence of Marfan Syndrome			

Most recent Immunizations / Dates: _____

Medications currently in use: _____

Additional Observations / Comments: _____

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HISTORY: Please indicate all areas where disease or alterations have occurred and explain below:

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies/Anaphylaxis | <input type="checkbox"/> Eczema / Skin | <input type="checkbox"/> Hospitalizations / Surgery |
| <input type="checkbox"/> Asthma / Respiratory | <input type="checkbox"/> Endocrine | <input type="checkbox"/> Musculoskeletal |
| <input type="checkbox"/> Cardiovascular / Murmur | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Neurological / Seizures |
| <input type="checkbox"/> Childhood diseases | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Other |

Explanation/Comments: _____

ACTIVITY CLEARANCE:

A. Student may participate in physical education and all sports: YES _____ NO _____

B. Cleared after completing evaluation for: _____

C. NOT CLEARED FOR: (check all that apply)

- | | | |
|------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Collision | <input type="checkbox"/> Contact | <input type="checkbox"/> Non-Contact |
| <input type="checkbox"/> Strenuous | <input type="checkbox"/> Moderate | <input type="checkbox"/> Non-Strenuous |

Diagnosis: _____

Recommendations: _____

VACCINATIONS:

	Date	Date	Date	Date	Date
DPT / DTaP					
Tdap					
OPV / IPV					
MMR					
Measles					
Mumps					
Rubella					
Hepatitis A					
Hepatitis B					
HIB / Prohibit					
Varicella					
Pneumococcal (PCV7)					
Meningococcal					
Influenza					
Other:					
Other:					

LEAD SCREENING: Date test performed: _____ Result: _____

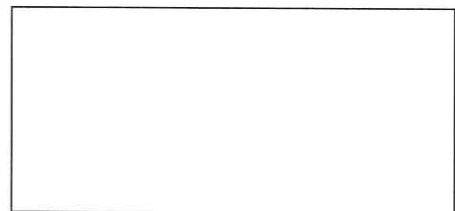
TUBERCULOSIS TESTING:

Mantoux: Date planted: _____ Date read: _____ Result: _____

Date planted: _____ Date read: _____ Result: _____

Chest X-ray Date: _____ Result: _____

INH Therapy: Date started: _____ Dosage: _____ Duration of Tx: _____



Physician / HCP Signature

Date

Stamp