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:			
Gross Hearing			
Nose/Mouth/Throat			
Lymph Glands			
Heart: *Murmurs/Rhythms*			
Lungs: *Auscultation/Percussion*			
Chest Contour			
Skin			
Abdomen: *Assessment (inc. liver/spleen)*			
Tanner Stage: *Testes/Onset of Menses*			
Hernia			
Neck/Back/Spine: *Range of motion*			
Scoliosis			
Upper Extremities			
Lower Extremities			
Neurological: *Balance & Coordination* *Romberg*			
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:*

_____ Allergies/Anaphylaxis
_____ Asthma / Respiratory
_____ Cardiovascular / Murmur
_____ Childhood diseases
_____ Eczema / Skin
_____ Endocrine
_____ Gastrointestinal
_____ Genitourinary
_____ Hospitalizations / Surgery
_____ Musculoskeletal
_____ Neurological / Seizures
_____ 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)

_____ Collision
_____ Strenuous
_____ Contact
_____ Moderate
_____ Non-Contact
_____ Non-Strenuous

Diagnosis: ____

Recommendations: ____

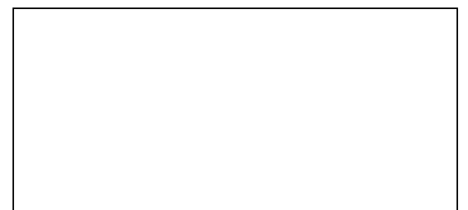
VACCINATIONS:

	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