TEANECK PUBLIC SCHOOLS
MEDICAL DEPARTMENT

PHYSICIAL EXAMINATION

Name: _____ Age: _____ Date of Birth: _____ Home Phone: _____
Address: _____ City/State/Zip: _____
School: _____ Grade: _____ Sex: _____
Physician: _____ Phone: _____ Fax Number: _____
Address: _____ City/State/Zip: _____

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH PAGES

Exam Date: _____ Height: _____ Weight: _____ Blood Pressure: ____/____ Pulse: ____ bpm.

Vision: R 20/ ____ L 20/ ____ Corrected: Y N Contacts: Y N Glasses: Y N Hearing: _____

	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	Absent		
Neck/Back/Spin: Range of Motion			
Scoliosis	Absent		
Upper Extremities			
Lower Extremities			
Neurological: Balance & Coordination Romberg:			
Evidence of Marfan Syndrome	Absent		

Most recent Immunizations/Dates: _____
Medications currently in use: _____
Additional Observations/comments: _____
_____

Continued on back page

HISTORY: ***Please complete all areas where disease or alterations have occurred and explain below.***

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

Explanation/Comments: _____
_____

CLEARANCE:

A. Student may participate in physical education and all sports: Yes ____ No ____ Date: _____

B. Cleared after completing evaluation for: _____

C. **NOT CLEARED FOR:** Collision _____ Contact _____ Non-Contact _____
Strenuous _____ Moderate _____ Non-Strenuous _____

Diagnosis: _____

Recommendations: _____

EXAMINED BY: Physician's/Provider's Stamp:

Family Physician/ Provider: ☐
School Physician: ☐
License Type:
MD/DO ☐
APN ☐
PA ☐

Physician's/Provider's Signature: _____ Today's Date: _____

VACCINE	TOTAL #DOSES	DATE	DATE	DATE	DATE	DATE
DPT/DTaP						
Tdap						
OPV						
IPV						
MMR						
Measles						
Mumps						
Rubella						
Hepatitis B						
HIB / Prohibit						
Varicella						
Pneumococcal (PCV7)						
Meningococcal						
RSV						
Gardisil						

Lead: Date Performed: _____ Record Value _____

Tuberculosis Testing

Mantoux tests: Date: _____ Result: _____ Date: _____ Result: _____
Chest x-ray Date: _____Result: _____
INH Therapy: Date Started: _____ Dosage: _____ How Long: _____