

PEQUANNOCK TOWNSHIP PUBLIC SCHOOLS

Health Office

PHYSICAL EXAMINATION

Name: _____ Date of Birth: _____ Grade: _____

School: _____

Medical History: _____

Each student must have a physical on file in the health office.

- | | | | | | | | | |
|-----|--------------------|-------|-------|---------|-------|-----|---------------------|-------|
| 1. | Urine | Sugar | _____ | Albumin | _____ | 13. | Skin | _____ |
| 2. | Pulse | _____ | | | | 14. | Head | _____ |
| 3. | Blood Pressure | _____ | | | | | Eyes | _____ |
| 4. | Height | _____ | | | | | Ears | _____ |
| | Weight | _____ | | | | | Nose | _____ |
| 5. | Vision | Right | _____ | Left | _____ | | Mouth | _____ |
| 6. | Hearing | Right | _____ | Left | _____ | | Teeth | _____ |
| 7. | Scoliosis | _____ | | | | | Neck | _____ |
| | Extremities | _____ | | | | | | |
| 8. | Neurological | _____ | | | | 14. | Abdomen | _____ |
| 9. | Heart | _____ | | | | | Hernia | _____ |
| | Murmur | _____ | | | | | Genitalia | _____ |
| | Rhythm | _____ | | | | 15. | Physical Maturation | _____ |
| 10. | Lungs | _____ | | | | | | |
| 11. | Immunization given | _____ | | | | 16. | Hgb/Hct | _____ |
| 12. | TB Test | _____ | | | | | | |

Other _____

Remarks _____

Date of Physical _____ Physician's Signature _____

Date of Signature _____

**Please print/type/stamp
your name, address and
telephone number**