Carlstadt Public School
550 Washington Street ◇ Carlstadt, NJ 07072
Phone: 201-672-3000

Family Physician Examination

CHILD'S NAME ____

ADDRESS____

Child's Date of Birth________________________ Age__________ Grade ___________________

Date of Physical Exam: ______________________________________

Height ________ **Weight**_______ **Blood Pressure**________ **Urine**_______ **Gender**_____**M** ______**F**
(check one)

EARS:		**EYES:**	
NOSE:		**TEETH/MOUTH:**	
THROAT:		**LUNGS:**	
HERNIA:		**THYROID:**	
ABDOMEN:		**LYMPH GLANDS:**	
GENITO-URINARY:		**SKIN:**	
NUTRITION:		**NERVOUS SYSTEM:**	
SPEECH:		**GENERAL APPEARANCE:**	
ORTHOPEDIC:		**ANY KNOWN ALLERGIES:**	
POSTURE/SCOLIOSIS:		**MEDICATIONS NEEDED IN SCHOOL:** **(MUST HAVE MD ORDER)**	
CARDIAC:		**other:**	

Is this child presently being treated for any illness, disability or injury? Yes_____ NO_____

Please give any pertinent medical/surgical history:

Signature of Examining Physician____

Physician's name (Please print/type)____

Physician's Address (Please print/type)____