LYNDHURST PUBLIC SCHOOLS
PHYSICAL EXAMINATION REPORT

PLEASE COMPLETE BOTH PAGES

Student's Name:_______________ Exam Date:_________ Age:______ DOB:___________

Address:_______________ City/St/Zip_______________ Phone #_______________

School:_______________ Grade:_____________ Sex: _______________

Physician:_______________ Phone:_____________ Fax: _______________

Address:_______________ City/St/Zip_______________

PHYSICIAN OR PROVIDER INFORMATION - PLEASE COMPLETE BOTH PAGES

Height:___________ Weight:___________ Blood Pressure:_____/_____ Pulse:_________bpm

Vision: R 20/_____ L 20/_____ Corrected: Yes/No Contacts: Yes/No Glasses: Yes/No

Hearing Screening: Date Performed:_________________ Note if Abnormal:_________________

	Normal	Abnormal Findings	Comments
Head/Neck			
Eyes/Sclera/Pupils			
Ears			
Nose/Mouth/Throat			
Heart: Murmurs/Rhythms			
Lungs: Auscultation/Percussion			
Chest Contour			
Skin			
Abdomen: Assessment (inc. liver, spleen)			
Tanner Stage: Testes/Onset of Menses			
Hernia	No	Yes/Possible	
Neck/Back/Spine Range of Motion			
Scoliosis:			
Upper Extremities			
Lower Extremities			
Neurological: Balance & Coordination			
Romberg			
Heel Walk			
Tandem Walk			
Nose Touch			
Toe Walk			

Most recent Immunizations/Dates: _______________

Medications currently in use: _______________

Additional observations:_______________

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PHYSICAL EXAMINATION REPORT

Student's Name:________________________________ Date of Birth:________________

A. Student may participate in athletics: Yes__________ No __________ Date:____________

B. Cleared after completing evaluation/rehabilitation for:________________________________

C. NOT CLEARED FOR: Collision__________ Contact__________ Non-contact__________

Strenuous________ Moderate________ Non-strenuous________

Diagnosis:____

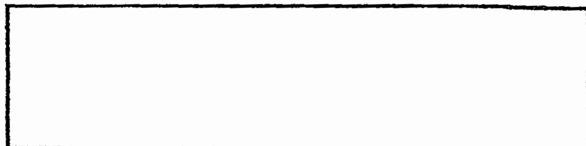
Recommendation: ____

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

Family Physician/Provider_________

School Physician______________

_____MD_____DO_____NP_____PA



Physician's/Provider's Signature:________________________

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combo If Td or DT, indicate in corner box					
Tdap					
POLIO-INACTIVATED POLIO Vaccine (IPV) If oral vaccine, indicate (OPV) in corner box.					
MEASLES,MUMPS,RUBELLA (MMR)					
HAEMOPHILUS B (HIB)**					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE**					
MENINGOCOCCAL					
HEPATITIS A ***					
HPV (HUMAN PAPILLOMAVIRUS)***					
OTHER					

LEAD SCREENING	
TEST DATE	RESULT

Document below single antigen vaccine receipt, serology titers, or varicella disease history

	Date	Titer
Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

☐Provisional admission attached - Date Granted__________ ☐Medical exemption attached ☐Religious exemption attached

History	Year	History	Year	History	Year
Juvenile Rheumatoid Arthritis		Allergies		Hepatitis	
Autism Spectrum Disorders		Asthma		Lyme Disease	
Hematological Disorders		Congenital Disorder		Mononucleosis	
OPERATIONS OR INJURIES:		Convulsive Disorder		Neuromusc. Disorder	
		Diabetes		Chronic Otitis Media	
		Drug Allergies		Auto Immune Disorders	
		Heart Disease		Strep Infections	

NOTE: IF THE CHILD IS EXEMPT FROM A VACCINE DUE TO IMMUNITY, A COPY OF THE LAB REPORT IS REQUIRED.