PLEASE RETURN THIS FORM TO YOUR SCHOOL NURSE

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

Other _____

Remarks _____
_____

Date of Physical _____ Physician's Signature _____

Date of Signature _____

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

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