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

Allison Evans - Superintendent

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**

EARS:		**EYES:**	
HEARING: MANDATORY FOR PRE-K		**VISION:** MANDATORY FOR PRE-K	
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)_____