BERLIN COMMUNITY SCHOOL NURSE'S OFFICE
856-767-0129, X205

PHYSICIAN HEALTH PHYSICAL– GRADES PK-4

Please take this form to your child's appointment and have completed at the time of the exam, then return it to the school nurse.

1. Student Information:

Child's Name:		Date of Exam:	
Grade:		Birth Date:	

Physical Exam		***Health History***	
Height:		Asthma:	
Weight:		Allergies:	
Blood Pressure:		Cerebral Palsy:	
Pulse:		Diabetes:	
Skin:		Eczema:	
Lymph System:		Epilepsy:	
Head:		Heart Murmur:	
Neck:		Frequent Colds:	
Mouth:		Ear Infections:	
Ears:		TB (Self/Family):	
Eyes:	R: L:	Accidents:	
Vision:	R: L:		
Chest:		Chronic Illness:	
Heart:			
Abdomen:		Surgeries:	
Genitalia:			
Back and Spine:		Other:	
Extremeties:			
Neurological:			

Any restrictions? _____

_____

Physician Signature: _____ Stamp:

Address: _____

Phone: _____