EAST BRUNSWICK MAGNET SCHOOL – PRIVATE PHYSICIAN PHYSICAL
(This CAN NOT be used for sports)

Student Namge_____**Birthdate:**_____**Grade**_____

STUDENT MEDICAL HISTORY:

- ☐ **Allergies*** (list)
- ☐ **Anxiety/Panic Attacks**
- ☐ **Appendicitis**
- ☐ **Asthma***
- ☐ **Bronchitis**
- ☐ **Concussion**
- ☐ **Constipation**
- ☐ **Depression**
- ☐ **Diabetes***
- ☐ **Fractures/Sprains**
- ☐ **Heart Disease**
- ☐ **Hermat murmur**
- ☐ **Lyme Disease**
- ☐ **Menstrual Cycle**
- ☐ **Migraines**
- ☐ **Mononucleosis**
- ☐ **Otitis Media**
- ☐ **Rheumatic Fever**
- ☐ **Seizures***
- ☐ **Sickle Cell***
- ☐ **Sinusitis**
- ☐ **Surgeries (list)**

School plan must be completed

- ☐ **Surgeries (list)**
- ☐ **Hospitalizations (list)**
- ☐ **Other (describe)**

☐ **Medications required during school hours***

PHYSICAL EXAM DATE: _____**PLEASE SUBMIT CURRENT IMMUNIZATION RECORD**

Height:	**Weight:**		**BP:**	**Pulse:**
HEARING	**Right**	**Left**	**Concerns:**	
VISION	**Right**	**Left**	**Both**	• **Glasses** • **No glasses**

GENERAL APPEARANCE: COMPLETE AND PROVIDE DETAIL AS NEEDED

EYES:	**LUNGS:**
EARS:	**ABDOMEN:**
NOSE:	**GENITALIA:**
MOUTH:	**PHYSICAL MATURATION:**
THROAT:	**NEUROLOGICAL:**
NECK:	**MUSCULATURE:**
CHEST:	**LYMPH NODES:**
HEART:	• **NO ABNORMALITIES NOTED**

I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and work unless noted above.

_____ _____

Physician Signature **Date**

_____

Physician Name **Physician Address** **Physician Phone Number**

Physician Stamp: