CEDAR GROVE PUBLIC SCHOOLS PHYSICAL EXAMINATION **DATE OF EXAM:** _____

STUDENT NAME: _____ **DOB:** _____ **SEX: M F GRADE:** _____

ADDRESS: _____ **CEDAR GROVE, NJ 07009**

HISTORY OF ILLNESS AND/OR SURGERIES: _____

VISION R 20/ L 20/ CORRECTED: YES NO GLASSES: YES NO CONTACTS: YES NO HEARING: R L

HEIGHT: _____%_____ **WEIGHT:** _____%_____ **BP:** _____/_____ **PULSE:** _____**BPM**

ALLERGIES: _____

ALLERGY CARE PLAN ATTACHED: YES NO

ASTHMA: _____ **ASTHMA TREATMENT PLAN ATTACHED: YES NO**

EARS: _____**EYES:** _____ **LYMPH GLANDS:** _____

THYROID: _____ **NOSE:** _____ **THROAT:** _____

TEETH: _____ **MOUTH:** _____ **GENITO-URINARY:** _____

HEART: _____ **MURMUR: YES NO LUNGS:** _____

ABDOMEN: _____ **HERNIA: YES NO**

ORTHOPEDIC: STRUCTUAL: _____ **POSTURE:** _____ **FEET:** _____ **SCOLIOSIS:** _____

SKIN: _____ **NUTRITION:** _____ **NERVOUS SYSTEM:** _____

SPEECH: _____ **GENERAL APPEARANCE:** _____

PSYCHO-SOCIAL CONCERNS: _____

WHAT IF ANY RESTRICTIONS ARE NECESSARY FOR FULL PARTICIPATION?_____

IS THE CHILD RECEIVING MEDICATION? _____ **OTHER THERAPY:** _____

IF YES, WHAT ARE THE SIDE EFFECTS WITH REGARD TO HIS/HER ACADEMIC PROGRESS? _____

HEALTH CARE PROVIDER'S NAME: _____ **SIGNATURE:** _____

ADDRESS: _____ **PHONE:** _____

IMMUNIZATIONS:

DTP/DTaP/Td	POLIO	MMR	HEPATITIS B	HIB	PREVNAR	VARICELLA
1_____	1_____	1_____	1_____	1_____	1_____	1_____
2_____	2_____	2_____	2_____	2_____	2_____	2_____
3_____	3_____	3_____	3_____	3_____	3_____	3_____
4_____	4_____		4_____	4_____	4_____	
5_____	5_____				5_____	

Tdap	MENINGOCOCCAL	HEPATITIS A	ADDITIONAL IMMUNIZATIONS:
1_____	1_____	1_____	_____
2_____		2_____	_____

MANTOUX: PLANTED _____ **READ** _____ **RESULT** _____ **BLOOD LEAD LEVEL:** _____