CARLSTADT PUBLIC SCHOOLS

CARLSTADT, NEW JERSEY 07072

FAMILY PHYSICIAN EXAMINATION

STUDENT NAME:____

Address:____

Date of Birth_____________________________ **Age:**___________**Grade:**______________

This physical examination form is to be completed by the family physician.

HEIGHT____________**WEIGHT**___________**BLOOD PRESSURE**___________**URINE**__________

EARS:

NOSE:

THROAT:

HERNIA:

ABDOMEN:

GENITO-URINARY:

NUTRITION:

SPEECH:

EYES:

TEETH/MOUTH:

LUNGS:

THYROID:

LYMPH GLANDS:

SKIN:

NERVOUS SYSTEM:

GENERAL APPEARANCE:

ORTHOPEDIC:

STRUCTURAL:

POSTURE:

SCOLIOSIS:

Is this child presently being treated for any illness, disability or injury?______**YES** ______**NO**

Please give any pertinent medical history:

Signature of Examining Physician____

Physician's Name (printed/typed)____

Physician's Address (printed/typed)____