CARLSTADT PUBLIC SCHOOLS

CARLSTADT, NEW JERSEY 07072

FAMILY PHYSICIAN EXAMINATION

STUDENT NAME:______________________________________

Address:____

Child's Date of Birth: _____________**Age:**______________**Grade:**______

This physical examination form is to be completed by the family physician.
Date of Physical EXAM_____________________

HEIGHT____________**WEIGHT**__________**BLOOD PRESSURE**__________**URINE**_____________

EARS:		**EYES:**	
NOSE:		**TEETH/MOUTH:**	
THROAT:		**LUNGS:**	
HERNIA:		**THYROID:**	
ABDOMEN:		**LYMPH GLANDS:**	
GENITO-URINARY:		**SKIN:**	
NUTRITION:		**NERVOUS SYSTEM:**	
SPEECH:		**GENERAL APPEARANCE:**	
ORTHOPEDIC:		**ANY KNOWN ALLERGIES:**	
STRUCTURAL:		**MEDICATIONS NEEDED IN SCHOOL:**	
POSTURE:		(MUST HAVE MD ORDER)	
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)____

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