VINELAND PUBLIC SCHOOLS
PHYSICAL EXAMINATION FORM
Part B

(Please return to the School Nurse)

TO BE COMPLETED BY FAMILY PHYSICIAN/PRACTITIONER:

NAME________________________ SEX________ BIRTHDATE____/____/____

PARENT OR GUARDIAN________________________ HOME PHONE____________

HOME ADDRESS____

SCHOOL________________________ GRADE________________________

HEALTH HISTORY (Please check, giving approximate dates)

Asthma ☐ Medication________________

Allergic reactions: Bee Sting ☐ Pollens ☐ Other____

Current Medications:________________

____

Ear Infections (chronic) ☐ Tubes ☐ ____________

Cardiac: Heart Murmur ☐

Restrictions to activity ________________

Kidney Problem ________________

Seizure Disorder ☐ Febrile ☐

Birth Defects/ Anomalies________________

Surgery________________

Injury/Fractures ________________

Current Therapies ________________

CHILDHOOD DISEASES – DATES

Chickenpox__________ German measles__________

Measles Mumps Other

OBJECTIVE DATA

PART A

☐ COPY OF IMMUNIZATION RECORDS ATTACHED

HEIGHT__________ WEIGHT__________

BLOOD PRESSURE__________ PULSE__________

VISION: Glasses_____ HEARING: H/Aid_____

Rt._____ Lt._____ Rt._____ Lt._____

Most recent Lead_____ Hgb_____ Sickle Status_____ PPD_____

PHYSICAL EXAMINATION (Please check normal, describe abnormal)

HEAD________________

EYES________________

EARS________________

NOSE________________

MOUTH & THROAT________________

TEETH__________ GUMS__________

NECK __________ THYROID __________

SKIN__________ GLANDS__________

POSTURE__________ SPINE__________

THORAX________________

HEART________________

LUNGS________________

ABDOMEN __________ HERNIA__________

GENITALIA________________

EXTREMITIES: ARMS_______ LEGS_______

HANDS_______ FEET_______

NEUROLOGICAL: GAIT__________

COORDINATION_______ REFLEXES_______

PUPILS__________

Comments/Certification of need for Special Services:

____

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________________________ DATE__________

PHYSICIAN'S SIGNATURE