215 Kipp Avenue Hasbrouck Heights NJ 07604
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PHYSICAL EXAMINATION REPORT

Name_____ Birthdate_____ Male_____ Female_____

Address_____ Town_____ Zip_____ Phone_____

Health History_____
Chicken Pox _____ Cancer _____ Fractures _____ Blood Disorders _____
Diabetes _____ Orthopedic Disorders _____ Strep Infection _____
Asthma _____ Defective Hearing _____ Rheumatic Fever _____
Epilepsy _____ Defective Speech _____ GI Disorders _____
Allergies _____ Operations _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____
Vision: R _____ L _____ Both_____ Glasses Needed _____
Hearing: R _____ L _____

Head and Neck _____ Lungs _____ Extremities _____
Nose _____ Heart _____ Neurological _____
Eyes _____ Abdomen_____ Urinalysis _____
Ears _____ Back _____ Hemoglobin/Hematocrit _____
Throat _____ Genitalia _____ Scoliosis Screening _____
Chest/Breast _____ Hernia _____

Allergic to Medication: Yes ___No ___If “Yes” type of medication _____

MMR _____ Measles _____ Mumps _____ Rubella _____ Booster _____
DPT _____ TDAP _____ Polio _____ Varicella _____
HIB _____Pneumonia _____Hepatitis B _____Meningitis _____ Influenza_____

Does the student require medication? Yes _____ No _____
Type of Mediation _____
If yes, a physician’s note is needed with diagnosis, name of medication and when it should be administered.

Parent’s Signature _____ Date _____

Physician’s Signature _____ Date _____