MONTCLAIR PUBLIC SCHOOLS
Physical Examination

Student's Name: _____ D.O.B. _____ Gender _____ Grade_____

Height _____ Weight _____ Blood Pressure _____ Pulse_____

Vision R ____ L____ Glasses _____ Contact Lenses _____ Hearing R ____ L____

Tuberculin Testing Type ____ Date _____Result_____ CXR ____ Treatment_____

Health Examination ✔ N = Normal ✔ A = Abnormal

	N	A	Comments
General Appearance			
Skin			
Nose, Throat			
Head, Scalp			
Eyes			
Ears			
Mouth, Teeth, Gums			
Chest, Lungs			Asthma _____
Heart			Murmur _____ If Yes, type _____
Abdomen			
GI, GU			
Musculoskeletal			Scoliosis _____
Emotional/Mental			
Behavior			
Language Development			
Nutrition			

Health History: Serious Illnesses, Surgery, Injuries _____

_____

Chicken Pox: ____Yes ____No If yes, date _____ Varivax Vaccine date:_____

Allergies: Food, drugs, seasonal, please list:_____

All Medication(s): _____

The examining health care provider is responsible for informing the school nurse of any defects which may hinder this child from full participation in the school health and physical education program.

PHYSICAL EDUCATION:

1. Full Activity Recommended:_____
2. Limited activity prescribed as follows: _____
   _____
3. Exclusion – Diagnosis: _____
   _____
4. Excluded from: _____ to: _____

Health Care Provider's Signature:_____ Provider's Stamp _____ Date:_____

Date of Physical Exam: _____

INDICATE ABOVE THE DATE WHICH VACCINE WAS GIVEN

Vaccine Type	1st Dose M/D/Y	2nd Dose M/D/Y	3rd Dose M/D/Y	4th Dose M/D/Y	5th Dose M/D/Y	M/D/Y
DPT or DTaP						
DT or TD						
IPV OR OPV						
MMR						
HEP B						
VARICELLA VAX			Disease			
OTHER -						
OTHER -						