WESTFIELD PUBLIC SCHOOLS, Westfield, New Jersey

PHYSICAL EXAMINATION

TO BE COMPLETED BY PHYSICIAN, PHYSICIAN'S ASSISTANT OR ADVANCED PRACTICE NURSE

LAST NAME: ____________ FIRST NAME: ____________ GENDER: ____________
ADDRESS: ____________ PHONE NUMBER: ____________ DOB: ____________

IMMUNIZATIONS: IMMUNIZATION RECORD ATTACHED ☐
MEDICAL EXEMPTION: Y ☐ N ☐ (MD Note required) RELIGIOUS EXEMPTION: Y ☐ N ☐

HEIGHT: ________ WEIGHT: ________ B/P: ________ HR: ________ R: ________
VISION: R: ________ GLASSES: R: ________ HEARING: R: ________
L: ________ L: ________ L: ________

ALLERGIES: ____________ REQUIRES EPINEPHRINE: Y: ☐ N: ☐

SKIN: ____________
JOINT/SPINE: ____________
EYES: ____________
EARS: ____________
NOSE/THROAT: ____________
LUNGS/CHEST: ____________ REACTIVE AIRWAYS: Y: ☐ N: ☐
ASTHMA: Y: ☐ N: ☐ TREATMENT PLAN: ________
MANTOUX DATE: ________ Result: ________
HEART: ____________ SIGNIFICANT CARDIAC HX: ________
ABDOMEN: ____________
NEUROLOGICAL: ____________ BEHAVIORAL ISSUES: ____________
MENTAL HEALTH DIAGNOSIS: ____________
DISEASE HISTORY: ____________
OPERATIONS/ INJURIES: ____________ DATE: ________
MEDICATIONS: ____________
OTHER: ____________
NORMAL EXAM: Y: ☐ N: ☐
SIGNIFICANT FINDINGS: ____________
RESTRICTIONS, IF ANY: ____________

☐ I HAVE REVIEWED CHILD'S HEALTH HISTORY AND THIS CHILD IS CLEARED TO PARTICIPATE IN ALL AGE-APPROPRIATE SCHOOL ACTIVITIES.

____________________ ____________________
PHYSICIAN'S/APN'S SIGNATURE & STAMP DATE OF EXAM