St. Joan of Arc School

**Marlton, NJ**

**PHYSICAL EXAMINATION**

**(To be completed by physician)**

***Child’s Name***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Birth date***: \_\_\_\_\_\_\_\_\_\_\_

# IMMUNIZATIONS *Please attach a copy*

# MEDICAL HISTORY

Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Kidney disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiac disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Neuromuscular disorders \_\_\_\_\_\_\_\_\_\_\_\_

Convulsive disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Congenital defects \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries or injuries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# PHYSICAL EXAMINATION

|  |  |  |  |
| --- | --- | --- | --- |
| Height | Weight | BP |  |
| Ears | Eyes | Nose | Throat |
| Teeth | Glands | Heart | Lungs |
| Abdomen | Hernia | Genito/urinary | Skin |
| Posture | Nervous system | Nutrition | Speech |
| Vision | Hearing |  |  |

**Tuberculin Test Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_**

**HISTORY OF LEAD LEVEL Screening from age 2-3 Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

( Kindergarten Requirement only)

General Appearance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this child regularly take medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments or recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature Date of exam Office stamp

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print: Physician Name