St. Joan of Arc School
Marlton, NJ
PHYSICAL EXAMINATION
(To be completed by physician)

Child's Name: _____ ***Birth date***: _____

IMMUNIZATIONS **Please attach a copy of the child's immunization records.**

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