

**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