EAST BRUNSWICK MAGNET SCHOOL – PRIVATE PHYSICIAN PHYSICAL

(This CAN NOT be used for sports)

STUDENT NAME:______________________________________DOB:____________________GRADE:________

STUDENT MEDICAL HISTORY:

- ☐ **Allergies*** (list) ____________________
- ☐ Anxiety/Panic Attacks
- ☐ Appendicitis
- ☐ **Asthma***
- ☐ Bronchitis
- ☐ Concussion
- ☐ Constipation
- ☐ Depression
- ☐ **Diabetes***
- ☐ Fractures/Sprains
- ☐ Heart Disease
- ☐ Hermat murmur
- ☐ Lyme Disease
- ☐ Menstrual Cycle
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Otitis Media
- ☐ Rheumatic Fever
- ☐ Seizures*
- ☐ **Sickle Cell***
- ☐ Sinusitis

SCHOOL PLAN MUST BE COMPLETED

- ☐ Surgeries (list)
- ☐ Hospitalizations (list)
- ☐ Other (describe)

☐ Medications required during school hours (list)____

*SCHOOL MEDICATION AUTHORIZATION FORM MUST BE COMPLETED FOR EACH MEDICATION LISTED

PHYSICAL EXAM DATE: _________________________*PLEASE ATTACH CURRENT IMMUNIZATION RECORD

Height:	Weight:	BP:	Pulse:

HEARING	Right	Left	Concerns:	
VISION	Right	Left	Both	☐ Glasses ☐ No glasses

GENERAL APPEARANCE: COMPLETE AND PROVIDE DETAIL AS NEEDED

EYES:	LUNGS:
EARS:	ABDOMEN:
NOSE:	GENITALIA:
MOUTH:	PHYSICAL MATURATION:
THROAT:	NEUROLOGICAL:
NECK:	MUSCULATURE:
CHEST:	LYMPH NODES:
HEART:	☐ NO ABNORMALITIES NOTED

I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and work unless noted above.

____ ______________

Physician Signature Date

____ STAMP:

Physician Name Address Phone