MAYWOOD PUBLIC SCHOOLS

Part B: Physical Examination Form

Student's Name: _____

Date of Birth:_____ Gender (circle): M F Age: _____ Grade/Teacher: _____

Parent/Guardian's Name: _____ Phone: _____

Address: _____

PHYSICIAN OR PROVIDER INFORMATION – COMPLETE BOTH SIDES

Physician: _____ Phone: _____ Fax: _____

Address: _____ City/State/Zip: _____

EXAM DATE: _____

Height:_____ Weight:_____ Blood Pressure: _____ / _____ Pulse:_____

Vision: R 20/ _____ L 20/ _____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

Muscle Balance: _____ Color Perception:_____

Hearing: R _____ L _____

	NORMAL	ABNORMAL FINDINGS	COMMENTS
Ears (otoscopic)			
Eyes / Sclera / Pupils			
Lymph Glands			
Thyroid			
Nose / Mouth /Throat			
Mouth - (inc. teeth)			
Chest Contour			
Heart: Rate / Rhythms **Murmur:**	Absent		
Femoral Pulses			
Lungs: **Auscultation / Percussion -**			
Abdomen: **Assessment- (inc. liver, spleen)**			
Tanner Stage: **Testes / Onset of Menses:**			
Hernia	Absent	Yes / Possible	
Genito- Urinary			
Neck / Back / Spine: **Range of Motion:**			
Scoliosis:	Absent		
Upper Extremities:(ROM, Strength, Stability)			
Lower Extremities:(ROM, Strength, Stability)			
Skin **(Infection, Scars, Jaundice, Purpura)**			
Nutrition			
Nervous System: **Balance & Coordination:**			
Speech			
Other			
General Appearance			

(Continue on other side)

Vaccine Type	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose	*LEAD*	*Screening*
Diphtheria, Tetanus, Pertussis (DTP)							
Tetanus, diphtheria, acellular pertussus (Tdap)							
Polio (indicate OPV or IPV)							
Measles, Mumps, Rubella (MMR)							
Haemophilus B (HIB) **							
Hepatitis B					**SEROLGY:**		
Varicella					Hepatitis B	Date:	Titer:
Pneumococcal Conjugate **					Varicella	Date:	Titer:
Meningococcal					Measles	Date:	Titer:
Hepatitis A ***					Mumps	Date:	Titer:
HPV (Human Papillomavirus) ***					Rubella	Date:	Titer:
Influenza							
Other:							

❑ Provisional admission attached- Date Granted: _____ ( ) Medical exemption attached ( ) Religious exemption attached

** Required for Day/Child Care Enrollees (2 months –5th Birthday ONLY) ***Not Required

Mantoux Test Date: _____ Result: _____ If Positive: Chest X-Ray Date:_____ Results:_____

INH Therapy Start Date: _____ End Date: _____

ALLERGIES: _____

Medications currently in use:

CLEARANCE: (Check the box that applies)

- ❑ Student is **cleared** for participation in all sports / physical activities without restriction.
- ❑ Student is **withheld clearance** for participation in any sport / physical activities until evaluation/ treatment of:

  _____
- ❑ **NOT CLEARED FOR**: _____ Contact / Collision _____ Non-Contact / Strenuous
  _____ Limited Contact _____ Non-Contact / Non-Strenuous
  Due to: _____

Additional Observations: _____

Diagnosis: _____

Recommendations: _____

EXAMINED BY: **Physician's Stamp:**

___MD ___DO ___APN___PA

Name:
Address:
City:
Phone #:

_____ **Today's Date:**_____

Physician's Signature

Date of Exam:_____