

CALIFON PUBLIC SCHOOL

6 School Street

Califon, NJ 07830

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PHYSICAL EXAMINATION Form

(To be completed by Physician)

Students Entering Grades K-4

NAME: _____ D.O.B.: _____ SEX: _____ GRADE: _____

HEIGHT: _____ BLOOD PRESSURE: _____ HEARING: _____ VISUAL ACUITY: _____

Right _____ O.D. _____

WEIGHT: _____ PULSE: _____ Left _____ O.S. _____

HEALTH HISTORY: _____ DATE of EXAM: _____

	NORMAL	ABNORMALITY	COMMENTS
SKIN			
EYES			
EARS			
NOSE-MOUTH			
THROAT			
CHEST			
HEART			
LUNGS			
ABDOMEN			
HERNIA			
MALE GENITALIA			
BACK			
EXTREMITIES			
NEUROLOGICAL			
PHYSIOLOGICAL MATURATION			

LIMITATIONS OF ACTIVITIES OR FURTHER RECOMMENDATIONS: _____

PHYSICIAN'S NAME & ADDRESS (Typed) _____

SIGNATURE: _____

**Return to Nurse's Office
Physical Exam Form K-4**

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