**GARFIELD PUBLIC SCHOOLS**

34 OUTWATER LANE, GARFIELD, NEW JERSEY 07026-2693

ANNA SCIACCA
SUPERINTENDENT

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# PHYSICAL EXAMINATION

NAME: _____ DATE: _____

DOB: _____ RESPIRATORY: _____

HEIGHT: _____ WEIGHT: _____ B/P: _____ PULSE: _____

VISION: WITHOUT GLASSES WITH GLASSES

OD_____ OS _____ OU _____ OD_____ OS _____ OU _____

## MEDICAL INFORMATION

| | | | |
|---|---|---|---|
| APPEARANCE | _____ | EXTREMETIES | _____ |
| SKIN | _____ | NEUROLOGICAL | _____ |
| HEAD | _____ | SENSORY | _____ |
| EARS | _____ | MOTOR | _____ |
| EYES | _____ | REFLEXES | _____ |
| NOSE/THROAT | _____ | ALLERGIES | _____ |
| MOUTH/TEETH | _____ | ASTHMA | _____ |
| CHEST/LUNGS | _____ | OTHER | _____ |
| ABDOMEN | _____ | | |
| HEART RATE | _____ | | |
| HEART RHYTHMN | _____ | | |

## IMMUNIZATION HISTORY

**MANTOUX:*** _____ RESULTS: _____ REFERRED: _____

Date Given: _____ Date Read: _____

***If the test was positive, proof of a negative chest x-ray is required.**

**DRUG SCREEN RESULTS**: (PLEASE INCLUDE A COPY) _____

COMMENTS: _____

_____

_____ _____ _____

PHYSICIAN'S SIGNATURE ADDRESS TELEPHONE #