Physical Examination Form

Student_____ Birth Date_____ Date of exam_____ (within 1 year of entry)
ALL ITEMS MUST BE COMPLETED: Height_____ Weight_____
Vision_____ Hearing_____ Blood Pressure_____
HEALTH HISTORY (INCLUDE PRENATAL, BIRTH AND DEVELOPMENTAL HISTORY)

DISEASE HISTORY(Please specify type and age of onset)

Allergies_____ Convulsive Disorders_____
Congenital Defects _____ Diabetes_____
Drug Sensitivities_____ Heart Disease_____
Hepatitis_____ Otitis Media_____
Neuromuscular Disorders_____ Rheumatic Fever_____
Asthma _____ Strep Infections_____
Chickenpox_____ Mononucleosis _____
Lyme Disease_____ Other Illnesses_____
Operations or Injuries _____

PHYSICAL	**Circle Yes= Abnormal No=Normal**				
Head/Neck	YES	NO	**Abdomen assessment (liver, spleen)**	YES	NO
Eyes/Sclera/Pupils	YES	NO	**Neck, Back, Spine ROM**	YES	NO
Ears	YES	NO	**Upper Extremities**	YES	NO
Nose/Mouth/Throat	YES	NO	**Lower Extremities**	YES	NO
Heart/Murmur/Rhythm	YES	NO	**Neurological (balance and coordination)**	YES	NO
Lungs	YES	NO	**Tanner Stage (testes/menses)**	YES	NO
Chest contour	YES	NO	**Absence of scoliosis**	YES	NO
Skin	YES	NO	**Absence of hernia**	YES	NO

Abnormal Findings/Comment_____
_____

MEDICATIONS CURRENTLY BEING USED_____

RECOMMENDATIONS OR RESTRICTIONS:_____

IMMUNIZATIONS RECORD (EXACT DATES—MONTH/DAY/YEAR-PHYSICIAN MAY ATTACH A SIGNED/STAMPED COPY OF IMMUNIZATION RECORD AS REQUIRED BY LAW)

Noble Leadership Academy Inc.
1-30 Summit Avenue, Fair Lawn, NJ 07410
|**T:** 973 685 2550 |**F:** 201 796 0357 |**E:** info@noblela.org |**W:** www.noblela.org

	#1	#2	#3	#4 (on/after 4th birthday)	#5
DTaP					
POLIO					
HEPATITIS B VACCINE					
RUBELLA VACCINE* (Given after 1st birthday)			OR	#1 MMR	
MUMPS VACCINE* (given after 1st birthday)				#2 MMR	
VARICELLA VACCINE * (after 1st birthday)			OR DISEASE DATE		
MENINGOCOCCAL (if born on or agter 1/1/97 and entering Grade 6 or from out of state or country)					
	*Or laboratory evidence of immunity is also acceptable.				

LEAD TEST DATE AND LEVEL (OPTIONAL) _____
MANTOUX_____ (On or after 4th birthday if born out of country).

I have examined this child and find him/her physically fit to participate in all school activities.

SIGNATURE OF PHYSICAN

_____
(Counter signatures are not acceptable)

PHYSICIAN STAMP

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