Bloomfield Department of Health and Human Services
Office of Public Health Nursing
Non-Public School Health Services

Saint Thomas the Apostle School

Preschool – Grade 2
PHYSICAL EXAMINATION FORM

To be completed, signed and stamped by Health Care Provider (HCP)

Student Name: _____ Grade: _____
Address: _____
_____ Phone: _____

HCP Name: _____
Address: _____
_____ Phone: _____

(Required)
Student Age: _____ DOB: _____ Male: _____ Female: _____

Height: _____ Weight: _____ B/P: _____ Vision: (R)_____ (L)_____ Hearing: (R)_____ (L)_____
Corrected? Y or N

IMMUNIZATION RECORD ⇒ PLEASE ATTACH COPY

GENERAL HEALTH REVIEW	Normal	Abnormal	Comments
Head/Neck			
Eyes (Glasses/Contacts Y or N)			
Ears			
Nose			
Throat			
Mouth/Teeth			
Heart			
Lungs (Asthma? Y or N)			
Abdomen			
Musculo-Skeletal			
Dermatological			
Neurological			
Genitalia			
Other			

Known Allergies: _____

Medications: _____

Does this child have medical clearance to participate in Physical Education Class, Intramural Sports and/or Interscholastic Sports?
YES_____ NO_____ Explain any limitations: _____

HCP SIGNATURE: _____ **HCP STAMP (required)**

DATE OF PHYSICAL: _____