Additional copies can be found at www.fpsk6.org

FAIRFIELD PUBLIC SCHOOLS
FAIRFIELD, N.J. 07004

HEALTH PHYSICAL FORM

NAME_____**DATE OF BIRTH**_____**GRADE**_____

HISTORY:

Allergies_____ Epipen: YES or NO Benadryl: YES or NO
(IF YES ACTION PLAN MUST BE COMPLETED)

Asthma _____Inhaler: YES or NO Nebulizer: YES or NO
(IF YES ACTION PLAN MUST BE COMPLETED)

ADHD/Type of Medication & Schedule_____

OTHER MEDICAL CONDITIONS OR ILLNESSES: _____

Medication Used: _____

Surgeries/Dates_____

Communicable Diseases_____Date_____

RECENT IMMUNIZATIONS/TESTS:

Immunization_____Date_____

T.B. Test (type) _____Date _____Result_____

PHYSICAL FINDINGS:

HEIGHT_____WEIGHT_____B.P._____GEN. APPEARANCE_____

Heart_____Lungs_____

Eyes/Vision_____ (Test Results) _____Ears/Hearing_____ (Test Results) _____

Glasses/Contacts: Circle YES or NO Hearing Aides: Circle YES or NO

Nutrition _____Skin _____

Nose _____ Throat _____ Thyroid_____

Teeth & Mouth _____ Lymph Glands_____

Orthopedic: Structural _____ **Scoliosis** _____

Extremities_____

Nervous System_____Menses_____Testes_____

Abdomen_____Hernia_____

Other_____

RESTRICTIONS (Physical Education, etc.) _____

_____ _____ _____
PHYSICIAN'S NAME/ADDRESS **PHYSICIAN'S SIGNATURE** **DATE OF PHYSICAL**