Date of exam:____________

SAINTS PHILIP AND JAMES SCHOOL
137 ROSEBERRY STREET
PHILLIPSBURG, NJ 08865

REPORT OF PHYSICAL EXAMINATION BY PRIVATE PHYSICIAN

NAME____ SEX___
(Last) (First) (Middle)

ADDRESS____
(Street) (City) (STATE) (ZIP)

DATE OF BIRTH__________PRESENT HEIGHT________PRESENT WEIGHT______

EXAMINATION: DO YOU FIND EVIDENCE OF ANY ABNORMALITY OF THE FOLLOWING?

Nutrition	Yes___No___	Blood Pressure	Yes___No___
Skin	Yes___No___	Lungs	Yes___No___
Allergies	Yes___No___	Abdomen	Yes___No___
Eyes	Yes___No___	Orthopedic	Yes___No___
Hearing Difficulty	Yes___No___	Skeletal	Yes___No___
Nose/Throat	Yes___No___	Genitals	Yes___No___
Teeth & Gingival Disease	Yes___No___	Neuro Muscular	Yes___No___
Glands	Yes___No___	Emotional Status	Yes___No___
Heart	Yes___No___	Scoliosis	Yes___No___

IF YES, TO ANY OF THE ABOVE, PLEASE ELABORATE.

MEDICAL HISTORY: SERIOUS ILLNESS, OPERATIONS, ACCIDENTS, HANDICAPPING CONDITIONS---(CONGENITAL OR ACQUIRED).

IS THE STUDENT UNDER TREATMENT? YES___ NO___

SHOULD THIS STUDENT HAVE RESTRICTIONS ON SPORTS OR PHYSICAL EDUCATION ACTIVITIES? YES___ NO___

OTHER RECOMMENDATIONS OR INFORMATION THAT MAY BE HELPFUL IN THE EMOTIONAL, SOCIAL OR PHYSICAL DEVELOPMENT OF THIS STUDENT.

MD NAME (print)______________________________
Address______________________________
Phone #______________________________

PHYSICIAN'S SIGNATURE______________________________DATE__________

PLEASE RETURN FORM AS SOON AS POSSIBLE

* Please attach immunizations