



HISTORY & PHYSICAL FORM

ST. MICHAEL SCHOOL – CRANFORD, NJ

This form must be completed by a physician and returned to the school by August 1 preceding the beginning of the academic year. If there is a problem, contact the school.

Student Name: _____ Date of Birth: _____

Street Address: _____

City, State Zip: _____

CODE: X = Normal 0 = Defect

Height: _____

Nose/Throat: _____

Weight: _____

Heart: _____

Blood pressure: _____

Lungs: _____

Vision: Right: _____

Abdomen: _____

Left: _____

Hernia: _____

Glasses Recommended: Yes No

Genito-Urinary: _____

Ears: Right: _____

Lymph Gland: _____

Left: _____

Skeletal/Extremities: _____

Hearing: _____

Scoliosis Check: _____

Skin: _____

Scalp: _____

Neurological: _____

Allergies: _____

Past Disease History: _____

Operations / Injuries: _____

Limitations from physical activities: _____

Is this child on medication? Why?: _____

IMMUNIZATION RECORD MUST BE ATTACHED

Signature of physician

Date of Exam

Physician's Office Address