

KEARNY PUBLIC SCHOOLS

ENTRANCE PHYSICAL EXAMINATION FORM

Student's Name _____

Age _____

Height _____ Weight _____ Blood

Pressure _____

Vision: Right _____ Left _____ Glasses (Yes/No) To be worn for

Scoliosis Exam _____ Nervous System (reflexes)

Heart _____ Lungs _____ Abdomen

Hearing _____ Throat _____ Nasal Passages

Skin _____ Allergies: (Yes/No) Type _____ Asthma

Medication

Genitals _____ Hernia _____ Skeletal System

History of Positive TB Reaction _____ INH _____ CXR

Mantoux: Date planted _____ Results _____ (May be read in school)

Is there any condition or history that we should be aware of?

Any limitations for Physical Education?

Date of Exam
Physician

Signature and Stamp of