Bayonne Public Schools

Bayonne, New Jersey

Report of Examination by Physician

School______ ______________________ Grade____

Child's Name ____ Date of Birth____

Address ____

Parent or Guardian's Name____ Phone_____________ __________________

RECORD OF EXAMINATION

Eye Muscle Balance (Important) Vision: Right_______________ Blood Pressure______________

Right_______________ Left________________ Height _____________

Left _______________ Both_______________ Weight ______________

Ears (otoscopic) ____________________________________ Speech ____

Hearing ____ Heart ____

Nutrition ____ Lungs ____

Teeth ____ Hernia ____

Gums ____ Skin ____

Tonsils and Throat ________________________________ Nervous System ____

Nose ____ Epilepsy ____

Glands – Cervical ___________________________________ Orthopedic:

Thyroid __________________________________ Spine____

Others Posture ____

Specify __________________________________ Feet ____

Abdomen ____ Tuberculin Test: Type_______________ Results _________________

Lead Test Date:_____________ Lead Level:_____________________

Genito-Urinary _____________________________________ General Condition ____

Have you any recommendations for medical or surgical care for this child?

Are there any recommendations to be observed in regard to activities, etc ?

Is there any further information you wish to give which will help us in regard to this child?

DATE OF EXAMINATION ____

SIGNATURE OF PHYSICIAN

Telephone Number _________________________________Address ____

(Please complete immunization record on attached form)