IMMACULATE CONCEPTION SCHOOL
41 MOUNTAIN AVENUE
SOMERVILLE, NEW JERSEY 08876

NURSE'S OFFICE: 908.725.9265
FAX: 908.725.3172

THIS FORM MUST BE COMPLETED BY A PRIMARY CARE PROVIDER.

STUDENT'S NAME ______________________________ *ALLERGIES* ____________________

DATE OF PHYSICAL ____________________ DOB ____________________ GRADE ____________

HEIGHT ____________________ WEIGHT ______________ BLOOD PRESSURE ______________

AUDIOMETRY: RIGHT EAR __________ LEFT EAR ____________________

VISION TESTING: RIGHT EYE __________ LEFT EYE __________ BOTH ________

CHECK IF NORMAL:

EYES ______________ SKIN ______________

EARS ______________ HEART ______________

NOSE ______________ LUNGS ______________

THROAT ______________ FEET ______________

SCOLIOSIS: Yes NO (Please circle) Hernia: Yes No (Please circle)

PHYSICAL EDUCATION RESTRICTIONS: ____

SIGNFICANT HISTORY; ABNORMALITIES NOTED: ________________________________

____

ALL MEDICATION CURRENTLY TAKING: ____

IMMUNIZATION DATES – PLEASE ATTACH VACCINE RECORD

TB (Mantoux) Date Tested: __________ Date Read: __________ RESULTS: ________mm Neg. Pos. (Please Circle)

____
Signature of Examiner

ID Stamp:

Rev. 1/18