MIDDLESEX COUNTY VOCATIONAL AND TECHNICAL HIGH SCHOOLS – PISCATAWAY CAMPUS
PRIVATE PHYSICIAIN PHYSICAL (This CAN NOT be used for sports)

Student Name: _____ Birthdate: _____ Grade: _____

STUDENT MEDICAL HISTORY: CHECK ANY THAT APPLY TO THE STUDENT.

- ☐ **Allergies*** (list): _____ ☐ Epi-Pen needed
- ☐ Anxiety/Panic Attacks
- ☐ Appendicitis
- ☐ **Asthma***
- ☐ Bronchitis
- ☐ Constipation
- ☐ Depression
- ☐ **Diabetes***
- ☐ Eczema
- ☐ Fractures/Sprain
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Lyme Disease
- ☐ Menstrual cycle
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Otitis Media
- ☐ Rheumatic Fever
- ☐ Scoliosis
- ☐ **Seizures***
- ☐ **Sickle Cell***
- ☐ Sinusitis
- ☐ Strep Throat
- ☐ Surgeries (list)
- ☐ Other (describe)
- ☐ **Medications required during school Hours***

*** School plan must be completed.**

PHYSICAL EXAMINATION DATE: _____ PLEASE SUBMIT CURRENT IMMUNIZATION RECORD.

Height:	Weight:	BP:	Pulse:

HEARING	Right	Left	Concerns:	
VISION	Right	Left	Both	☐ Glasses ☐ No glasses

GENERAL APPEARANCE: COMPLETE AND PROVIDE DETAIL AS NEEDED

EYES:	LUNGS:
EARS:	ABDOMEN:
NOSE:	GENITIALIA:
MOUTH:	PHYSICAL MATURATION:
THROAT:	NEUROLOGICAL:
NECK:	MUSCULATURE:
CHEST:	LYMPH NODES:
HEART:	☐ **NO ABNORMALITIES NOTED**

I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and work unless noted above.

_____ _____

Physician Signature **Date**

_____ **Physician Stamp:**

Physician Name

_____

Physician Address/Telephone Number