

MOUNT LAUREL TOWNSHIP SCHOOLS
PHYSICAL APPRAISAL FORM

NAME: _____ TELEPHONE: _____ DATE EXAMINED: _____

B/D: _____ SCHOOL: _____ GRADE: _____ C.A: _____

I. IMMUNIZATIONS:

VACCINE TYPE	PRIMARY SERIES			BOOSTERS			
	DISEASE M/D/Yr.	1st Dose M/D/Yr.	2nd Dose M/D/Yr.	3rd Dose M/D/Yr.	M/D/Yr.	M/D/Yr.	M/D/Yr.
DTaP (or DTP)							
Polio							
MMR Measles/Mumps Rubella							
Measles							
Rubella							
Mumps							
Varicella							
HIB							
Hepatitis B							
Influenza							
Pneumococcal							
Tdap							
Meningococcal							

II. PERTINENT HEALTH AND/OR MEDICAL HISTORY: Hearing and Vision must be completed

III.
 HEIGHT _____ WEIGHT _____ B/P _____ VISION OD OS HEARING R L
Acuity Decibel

Physical Examination - Completed by: _____

PRINT Physician's Name

	NORMAL	ABNORMAL
Ears		
Eyes		
Lymph Glands		
Thyroid		
Nose		
Throat		
Teeth - Mouth		
Heart		
Lung		
Abdomen		
Hernia		
Genito - Urinary		

	NORMAL	ABNORMAL
Orthopedic:		
Structural		
Postural		
Nervous System:		
Reflexes		
Gross Motor		
Bilaterally		
Fine Motor		

Please note any current health problems that may be affecting the student's learning process

Classification of physical activity: unlimited _____ modified _____ restricted _____
 Specify Instructions: _____

Signature of Physician/Date: _____