MIDDLESEX COUNTY MAGNET SCHOOLS – PISCATAWAY CAMPUS
PRIVATE PHYSICIAN 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	☐ Fractures/Sprain	☐ Rheumatic Fever	☐ Surgeries (list)
☐ Appendicitis	☐ Heart Disease	☐ Scoliosis	
☐ **Asthma***	☐ Heart Murmur	☐ **Seizures***	
☐ Bronchitis	☐ Lyme Disease	☐ **Sickle Cell***	
☐ Constipation	☐ Menstrual cycle	☐ Sinusitis	☐ Other (describe)
☐ Depression	☐ Migraines	☐ Strep Throat	
☐ **Diabetes***	☐ Mononucleosis	*** School plan must be completed.**	
☐ Eczema	☐ Otitis Media		

- ☐ **Medications required during school Hours***

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