

**Franklin Borough School**  
**Health Office**  
**50 Washington Ave.**  
**Franklin, NJ 07416**  
**973-827-9775 ext. 219**

**Physical Examination Form**

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Vision: \_\_\_\_\_

Hearing: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ TPR: \_\_\_\_\_

Significant Medical History/Allergies:  
 \_\_\_\_\_  
 \_\_\_\_\_

Nutrition		Ears	
Skin		Heart	
Eyes		Chest	
Teeth		Abdomen	
Gums		Extremities	
Nose		Spine	
Tonsils		Posture	
Adenoids		Hernia	
Goiter		Genitalia	
Lymph Nodes		Deformities	
Allergies		Speech Defects	
Epilepsy		Emotional Problems	
Operations		Behavioral Problems	

**DATES OF LAST IMMUNIZATIONS**

<b>IMMUNIZATION</b>	<b>DATE</b>
DPT Booster	
Td Booster	
MMR Booster	
Polio Booster	
Hepatitis Booster	
Varicella Booster	

Do you have any recommendations for the school to follow concerning the health status of this child?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Examining Physician's Signature

\_\_\_\_\_  
 Date