PILLAR
CARE CONTINUUM
Lifelong Support for People with Disabilities

Pillar Elementary School
51 Old Road
Livingston, NJ 07039
(973) 740-2353
Fax: (973) 740-8618

Pillar High School
71-77 Okner Parkway
Livingston, NJ 07039
(973) 535-1999
Fax: (973) 535-1262

PILLAR SCHOOLS
2023/2024 SCHOOL YEAR

**Physical Examination Report**

Date of Exam: _____

Student Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

**PHYSICAL EXAMINATION:**
Diagnosis: _____ BP _____

Head Cir. _____ Height _____ Weight _____ TPR _____

**ALLERGIES**: _____

**VISION:** _____
Suggested Follow Up (include Physician name and Contact Info): _____

**ORAL:** Any abnormality of teeth, gums, tongue, palate, etc.: _____

_____

Suggested Follow Up (include Physician name and Contact Info): _____

_____

**Auditory:** _____
Auditory evoked potential (if applicable): _____
Suggested Follow Up (include Physician name and Contact Info): _____

_____

HEENT: _____ NECK: _____
CHEST/BREAST: _____

**LUNGS:** _____
Asthma (If yes, include Asthma Action Plan): _____

**ABDOMEN:** _____
Any abnormalities? _____

**CARDIAC STATUS:** _____
Abnormalities/Results: _____
Suggested Follow Up (include Physician name and Contact Info): _____

_____

Echo Date Done (If applicable): _____

Student Name: _____ Date of Birth: _____

Any Limitations?  (Explain): _____

Suggested Follow Up (include Physician name and Contact Info): _____

_____

**URINARY TRACT AND BOWL INFECTIONS:**

Abnormalities: _____

Suggested Follow Up (include Physician name and Contact Info): _____

_____

**MUSCULOSKELETAL SYSTEM:**

Abnormalities: _____

Suggested Follow Up (include Physician name and Contact Info): _____

_____

**NEUROLOGICAL:**

Abnormalities: _____

Seizure History: _____

Suggested Follow Up (include Physician name and Contact Info): _____

_____

**SHUNT:** Date inserted: _____ Last Revision: _____

**SURGICAL PROCEDURES:**

1. Describe: _____

   Date Done: _____ Where performed: _____

2. Describe: _____

   Date Done: _____ Where performed: _____

3. Describe: _____

   Date Done: _____ Where performed: _____

### IMMUNIZATION STATUS

***Doctor's office, please attach immunization printout/record.

***Medical Exemption- *include documentation from physician.*

***Religious Exemption- *include parent statement.*

**RESTRICTIONS** *(please note any restrictions or precautions for physical activity):* _____

_____

_____

Physicians Name: _____ Date: _____

Physicians Signature: _____ Date: _____

Stamp: