



2078 Kennedy Boulevard
Jersey City, New Jersey 07305-1597

A. Harry Moore School
Medical Department
(201) 200-3135
(201) 200-2526 FAX

Student In-Take Physical Form

Student's Name	Date of Birth:
Address	Home No.
Parent/Guardian	Work No.
Medicaid No./Insurance No.	

Medical Diagnosis History: (Please include birth history)

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Does the student have a past or present medical history of the following? Please check all that apply.

Allergies _____ Asthma _____ Cancer _____

Congenital Heart Disease _____ Hearing Problems _____ Orthopedic Problems _____

Seizures _____ Tuberculosis _____ Vision Problems _____

	<u>Reason</u>	<u>Date</u>	<u>Place</u>
Hospitalizations:			
Surgery:			
Serious Illnesses:			
Serious Accidents:			
Other Problems or Limitations: _____			
<input type="radio"/> Full Physical Activity	<input type="radio"/> Adaptive Gym	<input type="radio"/> Restrictions _____ (Specify limitations and/or special alerts)	

Diet and Feeding Pattern:

Regular _____
Mashed _____
Chopped _____
Puree _____
Supplemental/Diet _____

G-Tube _____
Type/Method _____
Self-Feeder _____
Prone to Choking _____
NPO _____

Current Medications (Dosage & Frequency):

Seizure (Describe Type, Frequency):

General Appearance:

Height: _____	Weight: _____	Blood Pressure(if over 8years): _____
Face: _____	Ears: _____	
Eyes: _____	Fundi: _____	
Teeth: _____	Throat: _____	
Neck: _____	Lungs: _____	
Heart: _____	Murmurs: _____	
Abdomen: _____	Nutrition: _____	
Genitalia: _____	Skin: _____	

Extremities/Orthopedic Problems: _____

Muscle Strength: _____

Reflexes: _____

Limitation of Motion: _____

Fine Motor Coordination: _____

SCOLIOSIS: _____

Summary Recommendations: _____

PLEASE ATTACH COPY OF IMMUNIZATION RECORD

Recommended Placement at:

A. Harry Moore School _____

Do Not Recommend Placement at:

A. Harry Moore School _____

Physician's Name: _____

Physician's Phone: _____

Address: _____

Physician's Signature: _____

Date: _____