NEW JERSEY INSTITUTE FOR DISABILITIES
LAKEVIEW SCHOOL
10 OAK DRIVE
EDISON, N.J. 08837
732-549-5580 x2600

Medical Physical Form 2025-2026

NAME: _____ **Age:** _____ **DOB:** _____ **Male**_____ **Female** _____

Health History:

Medical Diagnosis Conditions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Immunizations: Please attach current copy of immunizations

Recent Hospitalizations/Surgeries (within past 2 years):

_____
_____
_____
_____

Feeding Problems: _____
(i.e., G-tube, NPO, etc.)

Special Diet: _____
(i.e., pureed, thickened liquid, etc.)

Seizures: **____ Yes** **____ No**

Frequency and type: _____

Allergies: (including medication allergies)

_____
_____
_____

Medications:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____
6. Name: _____
7. Name: _____

NAME: _____ **Age:** _____ **DOB:** _____ **Male** _____ **Female** _____

CLINICAL EXAMINATION:

Height: _____ **Weight:** _____ **Temperature:** _____ **Pulse:** _____ **Resp:** _____ **BP:** _____

SYSTEM	NORMAL (WNL)	ABNORMAL	COMMENTS
Eyes (glasses)			
Ears (hearing aids, indwelling tubes)			
Nose			
Throat			
Neck			
Teeth-Mouth			
Respiratory			
Cardiac			
Gastrointestinal			
Abdomen			
Hernia			
Genito-Urinary			

Muscular/Skeletal System: (Contractures, Spine, Scoliosis, Hips, etc.)

Scoliosis: Yes___ No ___ **Scoli Jacket**: Yes___ No ____ **Scoli surgery**: Yes ___ No ____

_____

_____

_____

Neurological System: (Seizure Disorder, Shunt, etc.)

_____

_____

_____

ADDITIONAL INFORMATION/RECOMMENDATIONS:
(Please indicate if there are limitations/restrictions regarding physical activities)

_____

_____

_____

PLEASE ISSUE PRESCRIPTIONS FOR EACH MEDICATION, SPECIAL DIET, EQUIPMENT, PROCEDURE(S), OR THERAPY.

_____ _____
Physician's Name (Print/Type) Date

_____ _____
Address Phone Number

PHYSICIAN'S SIGNATURE: _____