1ST CEREBRAL PALSY OF NEW JERSEY
7 SANFORD AVENUE, * BELLEVILLE, NEW JERSEY 07109
* PHONE (973) 751-0200 *FAX (973)-450-4722

ANNUAL PHYSICAL FORM TO BE COMPLETED, DATED, & SIGNED BY YOUR PHYSICIAN

NAME OF CHILD (LAST, FIRST, MI)	BIRTH DATE (MO/DAY/YR)	SEX: [ ] M [ ] F

PARENT	NAME	PHONE NO.
	ADDRESS	

VACCINE TYPE	DISEASE MO/YR	PRIMARY SERIES			BOOSTERS		
		1ST DOSE M/D/Y	2ND DOSE M/D/Y	3RD DOSE M/D/Y	M/D/Y	M/D/Y	M/D/Y
DTaP/DTP or Tdap							
POLIO							
HEPATITIS A							
HIB							
Hepatitis B							
MMR							
Pneumococcal							
Varicella							
Meningococcal							
Influenza							
HPV							

☐ *Medical Exemption Attached* ☐ *Religious Exemption Attached*

+PHYSICAL EXAMINATION+	
EARS (OTOSCOPIC)	
EYES	
NOSE	
TEETH-MOUTH	
THROAT	
THYROID	
HEART	
LUNGS	
ABDOMEN	
HERNIA	
GENITO – URINARY	
SKIN (NON-COMM.)	
NERVOUS SYSTEM	
ORTHOPEDIC	
SCOLIOSIS	

PHYSICAL EXAMINATION (CONT.)

NUTRITION	
SPEECH	
GENERAL APPEARANCE	
OTHER	

IS THIS CLIENT BEING FOLLOWED BY A FEEDING CLINIC? YES NO
IF NOT, WOULD YOU LIKE A REFERRAL? YES NO

HEIGHT: _____.

WEIGHT: _____.

BMI: _____.

BLOOD PRESSURE: _____

DISEASE HISTORY	TYPE			
ALLERGIES				
CONGEN. DEFECTS				
DRUG SENSITIVITIES				
HEPATITIS				
NEUROMUSC. DIS.				
SEIZURE DISORDERS				
	YEAR		YEAR	
CHICKEN POX		OTITIS MEDIA		
ASTHMA		RHEUMATIC FEVER		
DIABETES		STREP INFECTION		
HEART DISEASE		MONONUCLEOSIS		
OPERATIONS OR INJURIES		OTHER		

DENTAL

IS THE CLIENT FOLLOWED REGULARLY BY A DENTIST? YES NO

IF NOT, WOULD YOU LIKE A REFERRAL? YES NO

MEDICAL CONTRAINDICATIONS / **PRECAUTIONS** (I.E., PHYSICAL ACTIVITIES & FEEDING): _____

_____

_____

_____

IS THE CLIENT BEING TREATED BY A DOCTOR OTHER THAN THE CP CENTER DOCTOR? IF YES, FOR WHAT REASON? _____

RESULTS OF RECENT DIAGNOSIS OR PROCEDURE: _____

_____

_____

ADDITIONAL COMMENTS OR RECOMMENDATIONS: _____

_____

STAMP OR TYPE NAME AND ADDRESS & PHONE #

SIGNATURE OF PHYSICIAN: _____

DATE: _____