WINSLOW TOWNSHIP SCHOOL DISTRICT
REPORT OF PHYSICAL EXAMINATION

NAME:	SCHOOL:	GRADE:
ADDRESS:	TEACHER:	
PARENT/GUARDIAN:	BIRTHDATE:	AGE:
	HOME PHONE:	

The family physician or nurse practitioner shall examine this child and fill out the information below.
The school physician may review this report.

IMMUNIZATIONS: *Please record immunization dates (month, day, and year) including any boosters or other immunizations given during this visit. All immunizations must be kept up to date according to New Jersey state law.*

DtaP	**IPV**	**MMR**	**HIB (required PK)**	**HEP B**	**Varicella**
		#1			
		#2			

PCV(required PK)	**INFLUENZA(required PK)**	**TB MANTOUX**
		Date:
		Result:

CHILDHOOD ILLNESSES: please record dates in the spaces provided:

Chickenpox:	Frequent Ear Infections:	Hepatitis:
Lyme Disease:	Rheumatic Fever:	Strep Infection:
Other:		

SURGERY: please record dates in the spaces provided:

Adenoidectomy:	Appendectomy:	Herniorraphy:
Myringotomy:	Tonsillectomy:	Other:

MEDICAL HISTORY: (Yes/No) Please add detail if yes:

Allergies:	Asthma:	Convulsions:	Fractures:	Speech:
Hearing Problems:	Heart Problems:	Kidney Problems:	Visions Problems:	
Congenital Defects:				
Details:				

OTHER SIGNIFICANT HEALTH HISTORY and/or HOSPITALIZATIONS: Please add detail:

STATURE RECORD FOR THE LAST THREE YEARS:

	Year 1	Year 2	Year 3
Height:			
Weight:			

GENERAL APPEARANCE:

Blood Pressure:		
Head:	Gums:	Abdomen:
Eyes:	Throat:	Hernia:
Ears:	Neck:	Genitalia:
Nose:	Thorax:	Scoliosis:
Mouth:	Heart:	Extremities:
Teeth:	Lungs:	Feet:

NEUROLOGICAL:

Gait:	Coordination:	Reflexes:
Pupils:	Reaction to light:	Head Circumference:

VISION:

Pupils:	Right:	Left:
Without Glasses:	Right:	Left:
With Glasses:	Right:	Left:
Muscle Balance:	Color Vision:	

HEARING:

Right:	Left:

OTHER FINDINGS AND RECOMMENDATIONS: (please note below)

_____

1. Does this child have any communicable diseases or conditions? No ☐ Yes ☐
If yes, please describe:

2. Is this child receiving medication or other therapy? No ☐ Yes ☐
If yes, what are the implications with regard to progress:

3. Does this child have a health condition(s) which may require EMERGENCY ACTION while he/she is at school: such as seizures, insect allergies, food allergies, bleeding problems, diabetes, or heart problems? No ☐ Yes ☐
If yes, please describe:

4. Does this child have any other medical or physical problems the school nurse should know about? (frequent nosebleeds, headaches, etc.) No ☐ Yes ☐
If yes, please describe:

5. Should there be any restriction on physical activity or physical education in school? No ☐ Yes ☐
If yes, please specify nature and duration of restriction:

6. When should this child be examined again?
☐ I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all school activities, including physical education and competitive contact sports, unless noted above.

PRINT or STAMP Examining Physician's Name: _____

Address: _____ Phone_____

_____

Physician's Signature: _____ Date of Exam: _____