

WINSLOW TOWNSHIP SCHOOL DISTRICT

REPORT OF PHYSICAL EXAMINATION

NAME: _____ SCHOOL: _____ GRADE: _____

ADDRESS: _____ TEACHER: _____

_____ BIRTHDATE: _____ AGE: _____

PARENT/GUARDIAN: _____ 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: _____ Vision Problems: _____
 Congenital Defects: _____
Details: _____

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

STATURE RECORD FOR THE LAST THREE YEARS:
 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: _____
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 so, 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 so, 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: _____