

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 N.J. State Law.*

DtaP	IPV	MMR	HIB	HEP B	VARICELLA (Chicken Pox)
_____	_____	#1 _____	_____	_____	_____
_____	_____	#2 _____	_____	_____	OR
_____	_____	_____	_____	_____	Illness date _____
_____	_____	_____	_____	_____	<i>May be lab, physician or parent documentation</i>

PCV/PPV	INFLUENZA	MENINGOCOCCAL	Tdap	TB MANTOUX Date: _____	Result _____
_____	_____	_____	_____	_____	Other (Specify) _____
_____	_____	_____	_____	_____	_____

CHILDHOOD ILLNESSES: please **record dates** in the spaces provided:

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

SURGERY: please **record dates** in spaces provided:

Adenoidectomy: _____ Appendectomy: _____ Herniography: _____
 Myringotomy: _____ Tonsillectomy: _____ Other: _____

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

Allergies: _____ Asthma: _____ Convulsion(s): _____ Fractures: _____ Speech: _____ Hearing
 Problems: _____ Heart problems: _____ Kidney problems: _____ Vision: _____
 Congenital defect: _____
Details: _____

OTHER SIGNIFICANT HEALTH HISTORY and/or HOSPITALIZATIONS: Please detail as needed

Physical Record for the last three years:

Height: _____ Weight: _____

GENERAL APPEARANCE

Blood Pressure: _____

Head _____
Eyes _____
Ears _____
Nose _____
Mouth _____
Teeth _____

Gums _____
Throat _____
Neck _____
Thorax _____
Heart _____
Lungs _____

Abdomen _____
Hernia _____
Genitalia _____
Scoliosis _____
Extremities _____
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 seizure, insect allergy, food allergies, bleeding problem, diabetes, 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 nose bleeds, 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? _____

PRINT or STAMP Examining Physician's Name: _____

Address: _____

Telephone: _____

Examining Physician's Signature: _____ **Date of Exam:** _____