

Alloway Township School  
Physical Examination Report

*Please attach a copy of  
the child's current  
immunization record.*

For the School Year 2022-23

Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_

Significant Health History:

Allergies \_\_\_\_\_

Past Serious / Chronic Illnesses \_\_\_\_\_

Surgeries / Injuries \_\_\_\_\_

Hospital Admissions \_\_\_\_\_

Current Health Problems \_\_\_\_\_

Medications Taken Routinely \_\_\_\_\_

Physical Examination:

Date of Exam - \_\_\_\_\_

Height (inches) \_\_\_\_\_ Weight (pounds) \_\_\_\_\_ BP \_\_\_\_\_

Vision & Muscle Balance \_\_\_\_\_ Hearing \_\_\_\_\_

Lymph Glands \_\_\_\_\_ Heart \_\_\_\_\_ Feet \_\_\_\_\_

Thyroid \_\_\_\_\_ Lungs \_\_\_\_\_ Skin \_\_\_\_\_

Eyes \_\_\_\_\_ Abdomen \_\_\_\_\_ Nutrition \_\_\_\_\_

Ears \_\_\_\_\_ Hernia \_\_\_\_\_ Speech \_\_\_\_\_

Nose \_\_\_\_\_ Nervous System \_\_\_\_\_ Other \_\_\_\_\_

Throat \_\_\_\_\_ Skeletal \_\_\_\_\_ Date of last dental

Teeth/Mouth \_\_\_\_\_ Scoliosis \_\_\_\_\_ appt. \_\_\_\_\_

Past blood lead levels (date/level) \_\_\_\_\_

General Appearance \_\_\_\_\_

Do you recommend any activity limitations? Explain: \_\_\_\_\_

Do you recommend any school health accommodations? Explain: \_\_\_\_\_

Examining Physicians Name (please print) \_\_\_\_\_

Telephone Number \_\_\_\_\_

Examining Physician's Signature \* \_\_\_\_\_

Date \_\_\_\_\_

(\* Physician's personal signature – no cosigners or stamps please!)