Alloway Township School

Physical Examination Report

__________ School Year

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

Name ____________________

Birthdate __________ Gender __________ Grade __________

Significant Health History:

Allergies: ____________________

Past Serious/Chronic Illnesses ____________________

____

Surgeries/Injuries ____________________

____

Hospital Admissions ____________________

____

Current Health Problems ____________________

____

Routine Medications ____________________

____

Physical Examination:

Date of Exam __________

Height (inches) __________ Weight (lbs) __________ BP __________

Hearing __________ Vision & Muscle Balance __________

Lymph Glands __________ Heart __________ Feet __________

Thyroid __________ Lungs __________ Skin __________

Eyes __________ Abdomen __________ Nutrition __________

Ears __________ Hernia __________ Speech __________

Nose __________ Nervous Sys __________ Other __________

Throat __________ Skeletal __________ Date of last dental appt

Teeth/Mouth __________ Scoliosis __________ __________

Past blood levels (date/level) ____________________

General Appearance ____________________

Do you recommend any activity limitations? Please explain: __________

____

Do you recommend any school health accommodations? Please explain: __________

____

____________________ Examining Physician's Name (please print)

__________ Telephone Number

____________________ Examining Physician's Signature*

__________ Date

(Physician's personal signature - no cosigners or stamps, please!)*