WOODSTOWN-PILESGROVE SCHOOL DISTRICT
HEALTH OFFICES
WOODSTOWN, NJ 08098
STUDENT PHYSICAL EXAMINATION

Name________________________ Birth Date________________ Grade__________

IMMUNIZATIONS

***PLEASE ATTACH COPY OF COMPLETE IMMUNIZATION RECORD**

SIGNIFICANT HEALTH HISTORY

Allergies ________________________

Past Serious or Chronic Illnesses ________________________

Operations and Injuries ________________________

Admissions to Hospital ________________________

Current/Health Problems ________________________

Medications Taken Routinely ________________________

PHYSICAL EXAMINATION

DATE OF EXAM ________________

Height ________________

Weight________________

Blood Pressure ________________

Ears ________________

Hearing ________________

Eyes ________________

Vision ________________

Muscle Balance ________________

Lymph Glands ________________

Thyroid ________________

Nose________________

Throat ________________

Teeth/Mouth ________________

Date of Last Dental Appt. ________________

Heart ________________

Lungs________________

Abdomen ________________

Hernia ________________

Genito-Urinary ________________

Skeletal ________________

Scoliosis ________________

Feet ________________

Skin ________________

Nutrition ________________

Nervous System ________________

Speech________________

General Appearance ________________

Other ________________

Do you recommend any activity limitations? Explain ________________________

Do you recommend any school health accommodations? Explain ________________________

Physician's Signature________________ Date ________________ Phone ________________

Physician's Name (Print) ________________________