

Alloway Township School
Physical Examination Report

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

For the School Year 2018-2019

Name _____

Birthdate _____ Gender _____ Grade _____

Significant Health History:

Allergies _____

Past Serious / Chronic Illnesses _____

Surgeries / Injuries _____

Hospital Admissions _____

Current Health Problems _____

Medications Taken Routinely _____

Physical Examination:

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 _____

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!)