Alloway Township School
Physical Examination Report

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

For the School Year 2019-20

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!)