South River Public Schools
Office of the School Nurse

REPORT OF PHYSICAL EXAMINATION
SOUTH RIVER PUBLIC SCHOOLS

Dear Parents/Guardian:
Please present this form to your physician at the time of your child's examination. Upon completion, return to the school nurse at the address given above.

Student's Name: _____ **Date of Birth**: _____

Eye Exam: (Please circle one) With/Without Glasses With/Without Contacts
Right:_____ Left:_____ Both: _____

Hearing Exam: Normal_____ Abnormal_____

HEIGHT_____ **WEIGHT**_____ **BP**_____ **HR**_____ **TEMP**_____

DATES OF ALL IMMUNIZATIONS:

DPT	_____	_____	_____	_____	_____
DT	_____	_____	_____	_____	_____
POLIO	_____	_____	_____		
MMR	_____	_____			
MEASLES	_____	_____			
MUMPS	_____	_____			
RUBELLA	_____	_____			
HIB	_____	_____	_____	_____	
HEPATITIS B	_____	_____			
VARICELLA	_____	_____			
MENINGOCOCCAL	_____	_____			
HPV	_____	_____	_____		
OTHER	_____				

Mantoux Test Date: _____ **Date Read and Results:** _____

Physical Findings:	**Normal**	**Abnormal**	**Recommendations/Comments**
Ears			
Eyes			
Throat/Nose			
Teeth/Mouth			
Lymph Glands			
Thyroid			
Heart			
Lungs			
Abdomen			
Hernia			
Genitourinary			
Orthopedic/Scoliosis			
Skin			
Nutrition			
Nervous System			
General Appearance			

Please list any health problems that might interfere with the pupil's education:

_____

_____

_____

May student participate in the regular physical education program and/or other school activities? Yes_____ No_____

Indicate any restrictions:

_____

_____

_____

Signature of Examining Physician: _____

Stamp of Health Care Provider: _____

Address: _____

_____

Phone: _____

Date of Examination: _____