

SOUTHAMPTON TOWNSHIP SCHOOLS

in Historic Vincentown Village
Southampton, New Jersey 08088
Telephone (609) 859-2256

“Building a Tradition of Excellence”

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PHYSICAL EXAMINATION FORM

Preschool/Kindergarten physical due 30 days from start date (within last 365 days).

School Year: _____

Name: _____ Male _____ Female _____

Date of Birth: _____ Telephone #: _____ - _____ - _____

Parents/Guardians: _____

Address: _____

Immunization Record & Dates (update if necessary)

Type	1	2	3	4	Booster
DPT/DPaT	_____	_____	_____	_____	_____
OPV/IPV	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____
Measles	_____	_____	_____	_____	_____
Mumps	_____	_____	_____	_____	_____
Rubella	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____
TB Test: Type:	_____	_____	Menactra	_____	_____
Date:	_____	_____	Varicella	_____	_____
Results:	_____	_____	Other	_____	_____

Disease History (type and year)

Allergies: _____ Asthma: _____

Drug Sensitivities: _____ Insect Stings: _____

Diabetes: _____ Congenital Defects: _____

Heart Disease: _____ Convulsive Disorder: _____

Otitis Media: _____ Pulmonary: _____ Chest X-Ray: _____

Rheumatic Fever: _____ Streptococcal Infection: _____ Lyme Disease: _____

Other: _____

Operations or Injuries (type and year)

Communicable Diseases (dates)

Chicken Pox: _____ Measles: _____ Mumps: _____ Rubella: _____

Physical Examination (complete all info below)

Date of Examination: _____

Vision:

Without glasses Right Eye _____ Left Eye _____

With glasses Right Eye _____ Left Eye _____

Hearing: _____ Height: _____ Weight: _____

Blood Pressure: _____ HEENT: _____ Teeth/Mouth: _____

Thyroid: _____ Lymph Glands: _____ Heart: _____

Lungs: _____ Abdomen: _____ Hernia: _____

Neurologic: _____ Skin: _____ Speech: _____

Nutrition: _____

Orthopedic-Structures _____ Extremities _____

Posture _____ Feet _____

Other: _____

If applicable: G.U. _____ Genitalia: _____

Recommendations/Remarks: _____

Please print or type:

Examining Physician's Name: _____

*Doctor's Office Stamp

Phone #: _____

Address: _____

Physician's Signature: _____

Date: _____