READINGTON TOWNSHIP PUBLIC SCHOOLS

STUDENT HEALTH AND PHYSICAL EXAM FORM

Student's Name: _____ Birth Date: _____

Sex: ☐ Male ☐ Female

DISEASE HISTORY	TYPE/ YEAR	DISEASE HISTORY	TYPE/YEAR
Allergies		Diabetes	
Drug Sensitivities		Heart Disease	
Lyme Disease		Otitis Media	
Hepatitis		Rheumatic Fever	
Neuromuscular Disease		Strep Infections	
Asthma		Mononucleosis	
Chicken Pox		Vision Disorder	
Convulsive Disorder		Hearing Disorder	
ADHD		Congenital Defects	

OPERATION/INJURIES (PLEASE SPECIFY):

1.
2.
3.

ADDITIONAL COMMENTS:

IMMUNIZATIONS:

VACCINE TYPE	DISEASE DATE	1ST Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
DT(a)P/DT/Td						
OPV/IPV						
MMR						
Hepatitis A						
Hepatitis B						
Varicella						
Menactra						
Prevnar						
HIB						
Rotavirus						
Gardasil						

Mantoux (PPD)	Date administered:	Date read and results:

MEDICATIONS: _____

ALLERGIES:

Drug: _____ Food: _____

Environmental: _____

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Student's Name: _____ Exam Date: _____

Height:	Weight:	Pulse:	B/P:
Vision:	Uncorrected	Right:	Left:
Vision:	Corrected	Right:	Left:
Hearing Screen:		Right:	Left:

	Normal Exam	**Abnormal Findings:**
Head		
Eyes		
Ears		
Nose		
Throat		
Lymph Glands		
Heart		
Lungs		
Abdomen		
Hernia		
Genitalia		
Skin		
Orthopedic		
Scoliosis		
Neurological		
Speech		
Nutrition		

Any limitation of activity? : □ No □ Yes (Please define):

_____

_____

Physician's comments and recommendations:

_____

_____

Physician's signature: _____ Date: _____

Physician's name, address and telephone #:

_____

_____

_____

_____