Clark Public Schools
Clark, New Jersey

Student Health Examination: To be completed by Physician.

Student's Name _____ Date of Birth _____

Address _____ Phone ( ) _____

School _____ Sex: Male___ Female ___

Date of Examination _____ Weight _____ Height _____ B/P _____

Check each line	Normal	Abnormal	Needs Follow-up	Not Examined
Ears				
Eyes				
Lymph Glands				
Thyroid				
Nose				
Throat				
Teeth-Mouth				
Heart				
Lungs				
Abdomen				
Hernia				
Genital-Urinary				
Orthopedic				
Scoliosis				
Skin				
Nutrition				
Nervous System				
Speech				
General Appearance				

Does student have any health conditions requiring treatment? ___No ___ Yes
Specify: _____

Does student have any allergies? ___No ___ Yes Please list: Foods: _____

Medication Allergies: _____

Other: _____

Is student currently taking any Medication? Yes___ No___ If Yes, please list medications and reason for medication. _____

_____ _____
Physician (print or stamp) Physician Signature