Delaware Township School
PO Box 1000 – Sergeantsville, NJ 08557
Phone (609) 397-3179

Health Examination Record

(To Be Completed by Physician)

Name:_____ DOB: _____ Age: _____ Grade: _____

Height_____ Weight_____ Blood Pressure _____

Vision: R ____ L ____B____ With glasses: R____ L ____ B____ Hearing: R _____ L ____

Ears/nose/throat:_____ **Orthopedic:_____**
(include Scoliosis)

Teeth/mouth:_____ **Abdomen:_____**

Thyroid/lymph nodes:_____ **Genito/Urinary:_____**

Lungs:_____ **Speech:_____**

Heart:_____ **Physical Development:_____**

Skin:_____ **General Health:_____**

Nervous system:_____ **Nutrition:_____**

TB test date:_____ Result:_____

Allergies:

Medications:

Recommendations:

Approved for full participation in school and sports program: Yes: ____ No: ____

PLEASE ATTACH IMMUNIZATION RECORD

_____ _____ _____

Physician's Signature **Date of Exam** **Office Stamp**