Clark Public Schools
Clark, New Jersey

<u>Student Health Examination:</u> 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