EAST WINDSOR REGIONAL SCHOOL DISTRICT

DIVISION OF SCHOOL HEALTH SERVICES

Hightstown, New Jersey

MEDICAL EXAMINATION

Name:_____ Date Examined:_____
Last Name First Name

Sex:_____ Grade:_____ Date of Birth: _____

Height _____ Vision _____ Glasses/Contacts- Yes/No
Weight _____ Hearing _____
BP _____ Pulse _____

Skin _____ Neck/Head _____
Ears _____ Heart _____
Eyes/Sciera/Pupils _____ Lungs _____
Nose/Mouth _____ Abdomen _____
Gums/Teeth _____ Hernia _____
Chest Contour _____ Genito-Urinary _____
Tanner Stage _____ Scoliosis _____
Nodes _____ Orthopedic _____
Nutrition _____ Neurological _____

☐ Cleared for all activities without restrictions

☐ Cleared for all activities without restrictions with recommendations for further evaluation or treatment for _____

☐ Not cleared for physical education and recess pending further evaluation

Please attach a copy of the immunization information.

Mantoux Test:_____ Date Read:_____ Results: _____

Comments or recommendations _____

_____

_____
Doctor's Signature Date

_____
Doctor's Stamp