West Cape May School District
301 Moore Street
West Cape May, New Jersey 08204

Report of Physical Examination
For completion by the child 's physician.

Informe de examen físico
Para completar por el médico del niño.

Name: _____ DOB: _____

Date of Examination: _____

Significant Medical History: _____

CURRENT STATUS:

Weight: _____ Height: _____

Pulse: _____ Blood Pressure: _____ Respirations: _____

Are these within normal limits for this patient? ___yes ___no

Allergies: _____

Current Medical Conditions/ Medications: _____

GENERAL APPEARANCE:

Skin: _____ Ears (otoscopic): _____ Eyes: _____

Nose: _____ Throat: _____ Teeth/Mouth: _____

Neck: _____ Lymph Nodes: _____ Thyroid: _____

Hernia: _____ Abdomen: _____ Heart: _____

Lungs: _____ Orthopedic (Structural, Posture, Feet): _____

Extremities: _____ Menstruation: _____

Are there any modifications needed for full participation in the school program? ___No ___Yes

Physician's Comments: _____

_____

Examining Physician's Signature: _____

Examining Physician's Phone Number: _____

Visual Acuity: Tracking: _____ Muscle Balance: _____ Color: _____

Glasses ___yes ___no without glasses with glasses

Right	Left

Right	Left

Audiologic Screening: _____pass _____fail

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Doy mi consentimiento para que el Proveedor de atención médica y el Proveedor de cuidado infantil / Enfermera escolar de mi hijo discutan la información de este formulario.

_____

Signature firma Date fecha

Does Child Have Health Insurance? ¿El niño tiene seguro médico?

- ❑ Yes sí
- ❑ No

If yes, Name of Child's Health Insurance Carrier
En caso afirmativo, nombre de la compañía aseguradora del niño.

_____

IMMUNIZATIONS

- ❑ Immunization Record Attached
- ❑ Date Next Immunizations Due:_____