

**DR. GERALD H. WOEHR ELEMENTARY SCHOOL**  
**SCHOOL PHYSICAL EXAMINATION**  
**Phone #609-758-6800 x123 (for nurse)**  
**Fax #609-758-6868 Attn: Nurse**

**Student** \_\_\_\_\_ **Date of Exam** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**Date of Birth** \_\_\_\_\_ **Teacher Name** \_\_\_\_\_  
**Sex** \_\_\_\_\_ **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Blood Pressure** \_\_\_\_\_

**DISEASE HISTORY:** (please specify type and age at onset)

Allergies _____	Convulsive Disorder _____
Cong. Defects _____	Diabetes _____
Drug Sensitivities _____	Heart Disease _____
Hepatitis _____	Otitis Media _____
Neuromuscular Disorder _____	Rheumatic Fever _____
Asthma _____	Strep Infections _____
Chickenpox _____	Mononucleosis _____
Other Illnesses _____	
Operation or Injuries _____	

**PHYSICAL EXAMINATION:**

Ears (Otosopic) _____	Genetic-Urinary _____
Eyes _____	Orthopedic: _____
Lymph Glands _____	Structural _____
Thyroid _____	Posture _____
Nose _____	Feet _____
Throat _____	Skin _____
Teeth-Mouth _____	Nutrition _____
Heart _____	Nervous System _____
Lungs _____	Speech _____
Abdomen _____	General Appearance _____
Hernia _____	Other _____

**VISION** \_\_\_\_\_ **HEARING** \_\_\_\_\_

**IMMUNIZATION RECORD** (Please give full dates- month/day/year)

	#1	#2	#3	Booster#1	Booster#2
<b>DPT</b>	_____	_____	_____	_____	_____
<b>OPT</b>	_____	_____	_____	_____	_____
<b>MEASELS,MUMPS,RUBELLA</b> (given after 1 <sup>st</sup> birthday)	#1 _____	#2 _____			
<b>HIB#1</b>	#2 _____	#3 _____	#4 _____	<b>VARICELLA #1</b>	#2 _____
<b>HEPATITIS B #1</b>	#2 _____	#3 _____	<b>HEPATITIS A #1</b>	#2 _____	
<b>MANTOUX</b> (multiple puncture tests not acceptable)	<b>DATE</b> _____	<b>READING</b> _____			
<b>RECOMMENDATION OR RESTRICTIONS</b> (if any) _____					

I have examined this child and find him/her physically fit to participate in school activities.

_____ Name of Physician (printed)	_____ Signature of Physician
--------------------------------------	---------------------------------