

**CLEMENTON ELEMENTARY SCHOOL
4 AUDUBON AVENUE
CLEMENTON, NJ 08021
856-783-2300 / FAX- 856-783-8929
MEDICAL EXAMINATION FORM**

CHILD'S NAME _____ DATE OF BIRTH _____

***N.J. State Law Chapter 16 6A: 16-2.2 requires all students upon entry into school must have a medical exam. This includes all Pre-School, Kindergarten and new students in all grades.**

This Medical Examination form must be completed by your family physician in order for your child to enter school. Please return this form as soon as possible.

PHYSICAL EXAMINATION		
_____ WEIGHT	_____ TONSILS	_____ LUNGS
_____ HEIGHT	_____ TEETH	_____ ABDOMEN
_____ EARS _____ HEARING	_____ GLANDS	_____ GENITALIA
_____ NOSE	_____ HEART	_____ SKIN
_____ EYES	_____ POSTURE	_____ DEFORMITIES
_____ FEET	_____ NERVOUS SYSTEM	_____ BACK / SCOLIOSIS
ACUITY VISION RIGHT EYE:	ACUITY VISION LEFT EYE:	BLOOD PRESSURE: _____
HEALTH HISTORY		
_____ ASTHMA	_____ T.B. (Self or Family)	
_____ ALLERGY	_____ NEUROLOGICAL DISORDER	
_____ SKIN CONDITIONS	_____ SERIOUS ACCIDENTS	
_____ DEVELOPMENTAL PROBLEMS	_____ DIABETES	
_____ OPERATIONS	_____ HEART (Murmur)	
_____ FREQUENT COLDS, EAR INFECTIONS, ETC.	_____ INJURIES	
_____ MEDICATIONS	_____ OTHER	
_____ EPILEPSY	_____ CHRONIC ILLNESS	

PLEASE EXPLAIN ANY CONDITIONS THAT APPEAR ABOVE AND ANY CURRENT TREATMENT: _____

SIGNATURE OF PHYSICIAN

PHYSICIAN'S STAMP

DATE