Lodi Public Schools
School Health Services
Lodi, New Jersey 07644

Date:_____

Student:_____ DOB: _____ Sex: _____

Height:__ Weight: ____ Pulse: __ BP: __ Allergies:_____

Vision: Right Eye:____ Left Eye:_____ Both Eyes:____ Wears glasses/contact s? ____Y ____N
Hearing: Right Ear:_____ Left Ear:_____ Both Eyes:____
Does student require any special seating accommodation due to vision/bearing deficit? Y ____N

Heart *(include rate, rhythm and murmur)*_____

Lungs_____ Abdomen _____Hernia _____

Eyes _____Ears _____ Nose _____Throat _____

Teeth/Mouth _____ Skin Posture _____

Feet _____ Joints _____ Scoliosis _____
Neurological _____Genitalia _____

Please list past surgeries, injuries and/or illnesses: _____

_____

_____

Does student have any medical condition(s) which would limit school activity, inclusive of but not limited to physical education and sports? If yes, explain what the condition is and the restrictions: _

_____

_____

Is student taking any medication on a regular basis? If yes, please state the medication, dosage, schedule and possible side effects:_____

_____

_____

Is student using an inhaler, epi-pen or insulin and if yes, is that student capable of self-administration of

this medication? _Y_N List which of the above the student uses: _____

Please list most recent immunization dates: _____

_____

_____

_____
Physician/Healthcare Provider Signature

_____
Name

_____
Address

_____
Phone

(Please Stamp/Print Above)