Lodi Public Schools
School Health Services
Lodi, NJ 076744

Date of Exam:_____ Today's Date: _____

Student:_____DOB:_____ Sex: _____

Height: _____ Weight: _____ Pulse: _____ BP: _____ Allergies: _____

Vision: Right Eye: _____ Left Eye: _____ Both Eyes: _____ Wears glasses/contacts: _ Y _ N
Hearing: Right Ear: _____ Left Ear: _____
Does student require any special seating accommodation due to vision/hearing 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 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: _____
Any referrals made & to whom:

_____ _____
Physician/Healthcare Provider Signature Name

_____
Address

(Please Stamp/Print Above) _____
Phone