

MEDICAL EXAM FORM
OCEANPORT SCHOOL DISTRICT
 Oceanport, New Jersey

Student's Name _____ Age _____ Sex _____

Address _____

Date of Birth _____ Grade _____ Phone _____

1 Height _____ Weight _____

2. Blood Pressure _____ / _____ Pulse _____ bpm.

3. Vision Test R 20/ _____ L 20/ _____ B 20/ _____ Glasses: Y / N Contacts: Y / N

4. Audiometric Test _____

	Normal	Abnormal	Comments
5. Eyes	_____	_____	_____
6. Ears	_____	_____	_____
7. Nose	_____	_____	_____
8. Throat	_____	_____	_____
9. Skin	_____	_____	_____
10. Neck	_____	_____	_____
11. Lungs	_____	_____	_____
12. Heart	_____	_____	_____
13. Abdomen	_____	_____	_____
14. Hernia	Yes _____ No _____	_____	_____
Spleen	_____	_____	_____
Liver	_____	_____	_____
15. Genitalia	_____	_____	_____
Male Testes	_____	_____	_____
Female	_____	_____	_____
Menses	Yes _____ No _____	_____	_____
16. Tanner Classification	_____	_____	_____
17. Scoliosis Screen	_____	_____	_____
18. Extremities	_____	_____	_____
19. DTP	_____	_____	_____
20. Polio	_____	_____	_____
21. MMR #1	_____	#2 _____	_____
22. Haemophilus B (HIB)	_____	_____	_____
23. Hepatitis A Series #1	_____	#2 _____	_____
24. Hepatitis B Series #1	_____	#2 _____	#3 _____
25. Varicella (Chicken Pox)	_____	_____	_____
26. TB Screening (Mantoux Test)	_____	_____	_____
27. Pneumococcal Conjugate vaccine (PCY)	_____	_____	_____
28. Influenza vaccine	_____	_____	_____
29. Meningococcal Vaccine	_____	_____	_____
30. Other (<i>Specify</i>)	_____	_____	_____
31. Physician's Recommendations:	_____		

Date _____ Physician's Signature & Stamp _____ Rev. 2/13