Kenilworth School District

426 Boulevard Kenilworth, New Jersey 07033
Telephone (908) 276-5936 Fax (908) 276-7598

Student's Name:_____ Date of Birth:_____ Grade:_____

Parent/Guardian Name:_____ Examination Date:_____

History of Illness or Abnormalities: _____
_____

Height:_____ Weight:_____ Blood Pressure:_____

Ears (otoscopic)	_____	Hernia	_____
Eyes	_____	Genitourinary	_____
Lymph Glands	_____	Orthopedic: Posture	_____
Thyroid	_____	Feet	_____
Nose	_____	Skin	_____
Throat	_____	Nutrition	_____
Teeth/Mouth	_____	Nervous System	_____
Heart	_____	Speech	_____
Lungs	_____	Other	_____
Abdomen	_____	General Appearance	_____
		Scoliosis	_____

Vision without glasses right_____ left_____ both_____

with glasses right_____ left_____ both_____

Hearing right_____ left_____

Please indicate any limitations or restrictions that the child may have.

_____
_____

What medical factors in this child's history and/or examination may affect his/her growth, development and/or academic progress?

_____
_____

Is this child receiving medication or other therapy? What type?

_____
_____

If so, what are the side effects with regard to his/her progress in school?

_____
_____

Additional comments if necessary.

_____
_____

Exam Date _____

Doctor's Name (Print) _____

Doctor's Signature_____

Address_____

Phone Number_____

DOCTOR'S STAMP

ATTACH COPY OF IMMUNIZATION RECORD FOR NEW STUDENTS