

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) _____
 Eyes _____
 Lymph Glands _____
 Thyroid _____
 Nose _____
 Throat _____
 Teeth/Mouth _____
 Heart _____
 Lungs _____
 Abdomen _____

Hernia _____
 Genitourinary _____
 Orthopedic: Posture _____
 Feet _____
 Skin _____
 Nutrition _____
 Nervous System _____
 Speech _____
 Other _____
 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.

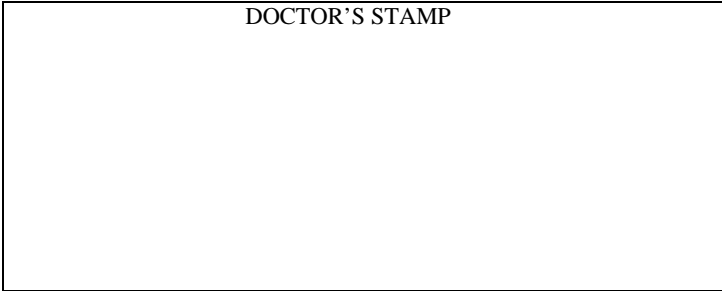
Exam Date _____

Doctor's Name (Print) _____

Doctor's Signature _____

Address _____

Phone Number _____



ATTACH COPY OF IMMUNIZATION RECORD FOR NEW STUDENTS