Colts Neck Township Schools
Pre- Entry Physical

This form is to be completed by your physician.. Please note the physical exam must be completed within one year prior to entry of school.

Name of Student: _____ Date of Birth: _____

Address: _____

Student's phone number: _____ Male ☐ Female ☐

Height: _____ Weight: _____ Blood Pressure: _____

Vision: R 20/_____ L 20/_____ Hearing: _____

Physical Examination	**Date of Physical:**
Ears (otoscopic): _____	Genito- Urinary: _____
Eyes: _____	Orthopedic
Lymph Glands: _____	Structural: _____
Thyroid: _____	Posture: _____
Nose: _____	Feet: _____
Throat/ Tonsils: _____	Skin: _____
Teeth/ Mouth: _____	Nutrition: _____
Heart: _____	Nervous System: _____
Lungs: _____	Speech/ Language: _____
Abdomen: _____	General Appearance: _____
Hernia: _____	Other: _____

Health History- Please specify type and age of onset

Allergies: _____	Lyme Disease: _____
Arthritis: _____	Migraines: _____
Asthma: _____	Mononucleosis: _____
Bladder/ Kidney: _____	Neuromuscular Disorder: _____
Chicken Pox: _____	Otitis Media: _____
Congenital Defects: _____	Rheumatic Fever: _____
Convulsions/ Seizures: _____	Strep Infections: _____
Diabetes: _____	Tuberculosis: _____
Drug Sensitivities: _____	Surgical Procedures/ Injuries:
Fainting Spells: _____	
Heart Disease: _____	
Hepatitis: _____	
High Blood Pressure: _____	Other:

Restrictions that may affect the student's participation in school activities/ physical education? _____

Significant developmental delays? _____

Signature of Physician: _____ Date: _____

Physician's Name: _____(print) Phone #: _____

Please provide Physician's stamp below

Revised 2/8/2008