

Galloway Community Charter School
 112 S. New York Road
 Galloway, NJ 08205
 Tel: 609-652-7118
 Fax: 609-652-3640

Student Name: _____
 Student Age: _____ D.O.B. _____
 Date of Exam: _____
 Height _____ Weight: _____
 Blood Pressure _____
 Pulse at rest _____

Allergies: _____

Student Physical	NORMAL	ABNORMAL	COMMENTS
Skin			
Eyes (Vision Screening)			
Ears (Screening)			
Nose			
Mouth/ Throat			
Neck			
Chest			
Lungs			
Heart			
Abdomen			
Spine/Scoliosis age (10)			
Extremities			
Testes			
Physiological maturation			
Neurological			
Allergies - Meds or Other			
Had Chicken Pox			

Is this student on any medications, over the counter or prescribed? YES _____ NO _____

Name of the Drug? _____

Remarks & Recommendations _____

Describe any limitations or any findings that have educational significance:

Please attach a copy of the student's immunization record!

Are the students immunizations up to date? Yes _____ No _____

Please Return this Form to:
 School Nurse
 Galloway Community Charter School

Physicians Signature

***PRINT* Doctor's Name in Full**



Physician's Phone # _____