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:

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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 # ____