Spring Lake Heights School
Spring Lake Heights, New Jersey

PHYSICAL APPRAISAL

Name of Child_____ DOB_____
Address_____ Age_____M/F (circle) Grade_____

IMMUNIZATION DATES – ATTACH A COPY OF IMMUNIZATIONS

Polio #1_____ #2_____ DPT #1_____ #2_____
#3_____ #4_____ DPT #3_____ #4_____
POLIO Boosters_____ DPT #5_____ Booster_____
MMR #1_____ #2_____ Meningitis _____
Mumps #1_____ #2_____ Varicella #1_____ #2_____
Rubella #1_____ #2_____ Hepatitis B #1_____#2_____#3_____
Measles #1_____ #2_____ Mantoux (date) _____(results)_____

PHYSICALS MUST BE COMPLETED WITHIN 365 DAYS OF ENROLLMENT

History of diseases, handicaps, operations_____
Allergies_____

Vision_____/_____ Hearing_____(Required)

Weight_____ Heart_____
Height_____ Lungs/Chest_____
Blood Pressure_____/_____ Orthopedic_____
Nose_____ Skin_____
Mouth/Dental_____ Pulse_____
Neurological_____ Ears_____
Testes_____ Abdomen_____

What medication is child receiving?_____

Physician's Comments_____
_____

Date of Physical_____Physician's Signature_____

Physician's stamp required