NEENAH JOINT SCHOOL DISTRICT

PHYSICAL EXAMINATION REPORT

Date of Examination_____

Name of Student_____ Birth Date _____ Grade _____

Parent/Guardian _____ School _____

Address _____ Phone _____

Medical Conditions of Concern

Physical Limitations or School Activity Restrictions

Immunizations: Please complete yellow immunization card.

Vision

Right 20/ _____ Left 20/ _____

Hearing

Right ear _____

Left ear _____

_____I would like the Nurse to contact me regarding this child.

_____I would like the Teacher to contact me regarding this child.

Signature of Examining Physician _____

Address _____ Phone _____

RETURN EXAM TO: Neenah Joint School District
Attn: School Nurses
410 South Commercial Street
Neenah WI 54956

Revised: January, 2014