

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. A print-out from your doctor is also acceptable.

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 THIS EXAM FORM TO YOUR CHILD'S SCHOOL WHEN COMPLETED.