OCEANPORT SCHOOL DISTRICT
Oceanport, NJ 07757
MEDICAL EXAM FORM

Student's Name:_____ Age:_____ Sex:_____

Date of Birth:_____ Grade:_____ Phone:_____

Height:_____ Weight:_____

Vision Test Rt._____ Lt._____ (a) Glasses_____ (b) Contacts_____

Audiometric Test:_____

Blood Pressure/Pulse Rate:_____

	Normal	Abnormal	Comment
Eyes	_____	_____	_____
Ears	_____	_____	_____
Nose	_____	_____	_____
Throat	_____	_____	_____
Skin	_____	_____	_____
Neck	_____	_____	_____
Lungs	_____	_____	_____
Heart	_____	_____	_____
Abdomen	_____	_____	_____
Hernia	_____	_____	_____
Spleen	_____	_____	_____
Liver	_____	_____	_____
Genitalia	_____	_____	_____
Male Testes	_____	_____	_____
Female	_____	_____	_____
Menstruation	_____	_____	_____
Tanner Classification	_____	_____	_____
Scoliosis Screen	_____	_____	_____
Extremities	_____	_____	_____

DPT_____ Polio_____ MMR_____
Hepatitis B Series #1:_____ #2:_____ #3:_____
Mantoux (Highly Recommended)_____

Physician's Recommendations:_____
_____
_____

Date:_____ Physician's Signature:_____

Maple Place Nurse's Office (fax): 732-229-0961
(Rev. 8/2021)