SAINT JEROME SCHOOL
250 Wall Street
West Long Branch, New Jersey 07764
Phone (732) 222-8686 Fax (732) 263-0343

**STUDENT HEALTH HISTORY AND PHYSICAL EXAMINATION**

Student Name _____ Date of Birth _____

Age _____ Sex _____ Grade _____ Date of Last Physical Examination _____

## Immunizations

Please attach a copy of student's most recent immunization record.

## Health History

Allergies: Yes ☐ No ☐ If yes, please list: _____

Medications: Yes ☐ No ☐ If yes, please list: _____

Surgical History: Yes ☐ No ☐ If yes, please explain: _____

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|---|---|---|---|
| Diabetes | Yes ☐ No ☐ | Central Auditory Processing Disorder | Yes ☐ No ☐ |
| Asthma | Yes ☐ No ☐ | Depression | Yes ☐ No ☐ |
| Heart Disease | Yes ☐ No ☐ | Attention Deficit Disorder | Yes ☐ No ☐ |
| Chronic Migraines | Yes ☐ No ☐ | Neuromuscular Disorder | Yes ☐ No ☐ |
| Seizure Disorder | Yes ☐ No ☐ | Speech Deficit | Yes ☐ No ☐ |
| Scoliosis | Yes ☐ No ☐ | Other _____ | |

## Physical Examination

**Height _____ Weight _____ B/P _____ Visual Acuity (R) _____ (L) _____**

Ears / Hearing _____ Eyes / Glasses _____

Cardiovascular _____ Pulmonary _____

Gastrointestinal _____ Genitourinary_____

Orthopedic _____ Neurological _____

Endocrine _____ Skin _____

Physician Signature and Stamp _____ Date _____