EAST GREENWICH TOWNSHIP SCHOOLS

Report of Physical Examination

Pupil's Name _____ M__ F__ Date of Birth_____
Address _____ Grade _____
Parent Guardian _____
Height _____ Weight _____ Blood Pressure _____ Pulse _____
Significant Medical History: _____
_____
Medications: _____
Allergies: _____
_____
Significant Social History: _____
_____
General Appearance: Date of Exam _____

Skin:	Neck:	Genitalia:
Eyes:	Thyroid:	Posture:
Ears:	Lungs:	Spine:
Nose:	Thorax:	Feat:
Mouth:	Heart:	Extremities:
Throat:	Abdomen:	Neurological:
Teeth:	Hemia: present / absent	Other:

If there are any modifications that are required for full participation in the school program please state them below:
_____
Screenings: ***Please give specific results!***

Visual Acuity @ 20 feet	Hearing Acuity @ 20 decibels	Scoliosis Screening (10 & older)
R 20/ L 20/ Both together 20/	R pass / fail L pass / fail	pass / fail

If you believe this child needs further evaluation by an ophthalmologist, audiologist, otologist, neurologist or other, please state specialist and your recommendations: _____
_____
_____
Child's Physician's Name and Title (Print) _____
Address and Phone Number _____
Child's Physician's Signature _____
Date _____