Greenwich Township School District

2016 - 2017 Report of Physical Examination

To be completed by parent/guardian:

Pupil Name: ____ DOB: ____ Grade: ____ Gender: ____

Physician Name: ____ Telephone Number: ____

To be completed by physician:

Please list all allergies to medications/foods/other. ____

Please list all serious illnesses, injuries and operations. ____

Please list all current medications. ____

Height: ____ Weight: ____ Pulse: ____ Blood Pressure: ____ Hearing (passed/failed): ____

Visual Acuity: OS ____ OD ____ OU ____

Evaluation	Normal Finding	Abnormal - Describe
Ears		
Eyes		
Lymph Glands		
Thyroid		
Nose		
Throat		
Teeth - Mouth		
Heart		
Lungs		
Abdomen		
Hernia		
Genito-urinary		
Orthopedic - Structure/Posture/Feet		
Skin		
Nutrition		
Nervous System		
Speech		
General Appearance		
Other		

Date of Exam: ____ Physician Signature: ____ Date: ____