Greenwich Township School District
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: _____