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: ______________________________________

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Significant Social History: ______________________________________

____

General Appearance: Date of Exam ______________

Skin	______	Neck	______	Genitalia	______
Eyes	______	Thyroid	______	Posture	______
Ears	______	Lungs	______	Spine	______
Nose	______	Thorax	______	Feet	______
Mouth	______	Heart	______	Extremities	______
Throat	______	Abdomen	______	Neurological	______
Teeth	______	Hernia	present / absent		

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

R 20/____ **L** 20/____ **Both together** 20/____

Hearing Acuity @ 20 decibels (circle)

R pass / fail L pass / fail

Scoliosis Screening (10 & older) (circle)

pass fail

If you believe this child needs further evaluation by an ophthalmologist, audiologist, otologist, neurologist or other, please state specialist and your recommendations: ______________________________________

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______________________ ______________________ __________

Child's Physician's Signature Address and Phone Number Date

______________________ **(Print Physician's Name and Title)**