EAST GREENWICH TOWNSHIP SCHOOL DISTRICT

Report of Physical Examination

Pupil'sName_____M___F___ Date of Birth_____
Address_____Grade_____
Parent/Guardian_____
Height_____ Weight_____ Blood Pressure_____ Pulse_____

Significant Medical History:

_____

_____

Medications:_____
*A*llergies:_____
Significant Social History: _____

General Appearance: _____ **Date of Exam_____**

Skin_____
Eyes_____
Ears_____
Nose_____
Mouth_____
Throat_____
Teeth_____

Neck_____
Thyroid_____
Lungs_____
Thorax_____
Heart_____
Abdomen_____
Hernia present/absent

Genitalia_____
Posture_____
Spine_____
Feet_____
Extremities_____
Neurological_____

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 ft
R20/___ **L**20/___**Both**20/___

Hearing Acuity @ 20 dB
R pass/fail **L** pass/fail
(circle)

Scoliosis Screening (10 & older) Pass / Fail
(circle)

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 Signature Address and Phone Number Date
_____**(Print Physician's Name and Title / Stamp)**