HILLSBOROUGH TOWNSHIP PUBLIC SCHOOL SYSTEM

ROUTINE PHYSICAL EXAMINATION REPORT

STUDENT'S NAME: **GRADE**:

DATE OF BIRTH:

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH SIDES

This section MUST be complete in order for this form to be accepted!

Height: _____ Blood Pressure: _____ Hearing: R_____ L: _____

Weight: _____ Pulse: _____ bpm Vision: 20/ _____ L 20/ _____

Correction: Y / N Contacts: Y / N Eyeglasses: Y / N

Indicators		Normal? (circle One)		Abnormal Findings/Comments
Head/Neck		YES	NO	
Eyes/ Sclera/Pupils		YES	NO	
Ears		YES	NO	
Nose/ Mouth/ Throat		YES	NO	
Heart: Murmurs/ Rhythms		YES	NO	
Lungs: Auscultation/Percussion		YES	NO	
Chest Contour		YES	NO	
Skin		YES	NO	
Abdomen: Assessment (inc. liver, spleen)		YES	NO	
Tanner Stage: Testes/Onset of Menses		YES	NO	
Hernia? (if yes/possible, please explain)		YES/ possible	NO	
Neck/Back/Spine: Range of Motion		YES	NO	
Scoliosis		YES	NO	
Upper Extremities		YES	NO	
Lower Extremities		YES	NO	
Neurological Balance & Coordination:		YES	NO	
	Romberg	YES	NO	
	Heel Walk	YES	NO	
	Tandem Walk	YES	NO	

*****MAKE A COPY FOR YOUR CHILD'S HOME HEALTH FILE*****

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	Nose Touch	YES	NO	
	Toe Walk	YES	NO	

STUDENT'S NAME **GRADE**:

PHYSICIAN OR PROVIDER MUST CONTINUE TO PROVIDE THE INFORMATION BELOW

Medications currently in use:
ATTACH COPY OF COMPLETE IMMUNIZATION RECORD
Allergies: Yes / No LIST Allergies, if any:
Additional Comments:

General Diagnosis:

Recommendations:

EXAMINED BY: Health Care Provider _____
School Physician _____

I hereby certify that the above named student was examined by me and found physically fit to engage in all physical activity, including physical education and recess.

Health Care Provider's Signature_____

Circle ONE: MD DO NP PA

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ROUTINE PHYSICAL EXAMINATION REPORT

EXAMINATION DATE: _____

↑**PLEASE STAMP WITH OFFICE STAMP**↑

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