

WARREN TOWNSHIP SCHOOL  
PHYSICAL EXAMINATION FORM- ELEMENTARY

<b>COMPLETED BY PARENT</b>	Student Name (Last, First, MI)	Date of Birth	Gender M      F
	Parent/Guardian	Phone (With Area Code)	
	Address		

**COMPLETED BY PHYSICIAN:**

Physical Examination: Each area of the examination form **MUST BE COMPLETED** with examination results. Checks are **NOT** adequate documentation of results.

Height:	Weight:	Blood Pressure:	Allergies?	Taking Medications?
Has Student had Eye Exam? Yes      No	Visual Acuity R 20/ L 20/ With Correction? Yes      No	Audiogram Results:	Please List:	Please List:
Glasses?      Contacts? Yes No      Yes No				

<b>Abdomen:</b>	<b>Eyes:</b>	<b>Skin:</b>
<b>Chest Contour:</b>	<b>Ears:</b>	<b>Head:</b>
	<b>Nose:</b>	
<b>Lungs:</b>	<b>Heart:</b>	<b>Throat:</b>
	<b>Rate &amp; Rhythm</b>	<b>Teeth:</b>
<b>Genito-Urinary:</b>	<b>Thyroid</b>	<b>Mouth:</b>
	<b>Range of Motion:</b>	
<b>Hernia?    Yes      No</b>	<b>Spine:</b>	<b>Extremities:</b>
<b>Neurological:</b>	<b>Range of Motion:</b>	
<b>(Balance-Coordination- Abnormal Reflexes)</b>	<b>Curvature of Spine:</b>	

**Additional Comments:** \_\_\_\_\_

**Other Special Problems:** \_\_\_\_\_

**Approved for Sports:** \_\_\_\_\_

**Rejected for Sports:** \_\_\_\_\_ **Reason:** \_\_\_\_\_

**Date of Examination:** \_\_\_\_\_ **Physician Signature:** \_\_\_\_\_

(Completed within 365 days prior to entry into school and submitted on entry.)

(Must be licensed in the State of New Jersey.)  
**Physician Stamp and License Number:**