

Springfield Township School
Jobstown, New Jersey
Physical Examination

Student's Name _____ Grade _____

Parent or Guardian _____ Birthdate _____

Address _____

Phone No. _____ Sex _____ Height _____ Weight _____

Hearing: Right Ear _____
Left Ear _____

Vision: Without Glasses
Right Eye _____

Blood Pressure _____

Left Eye _____

Known Allergies

With Glasses

General Appearance _____

Right Eye _____
Left Eye _____

Nutrition _____

Current Medications and Reason For

Ears (otoscopic) _____

Nose _____

Throat _____

Previous Injuries

Lymph glands _____

Thyroid _____

Teeth - Mouth _____

Operations & Date

Throat _____

Heart _____

Lungs _____

*Immunizations given at this time

Abdomen _____

Hernia _____

Additional Comments

Genito-Urinary _____

Orthopedic - structural _____

posture _____

Physician's Signature

feet _____

*Scoliosis Screening (age 10 and over)

Physician's Printed Name

Nervous System _____

Phone # _____

Speech _____

Date of Examination _____