HARMONY TOWNSHIP SCHOOL

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REPORT OF PHYSICAL EXAMINATION BY HEALTH CARE PROVIDER

Student Name: _____ Sex: M or F

Address: _____

Date of Birth: _____ Birth Weight: _____

Current Height: _____ ***Current Weight***: _____ ***Blood Pressure***: _____

Physical Examination: Is there evidence of any abnormality of the following:

Cardiac	Yes ____	No ____	Blood Pressure	Yes ____	No ____
Endocrine	Yes ____	No ____	Nutrition	Yes ____	No ____
Lungs	Yes ____	No ____	Nose/Throat	Yes ____	No ____
Abdomen	Yes ____	No ____	Scoliosis	Yes ____	No ____
Eyes	Yes ____	No ____	Musculoskeletal	Yes ____	No ____
Hearing	Yes ____	No ____	Genitalia	Yes ____	No ____
Emotional status	Yes ____	No ____	Skin	Yes ____	No ____
Neurological	Yes ____	No ____	Teeth/gingiva	Yes ____	No ____

Abnormalities noted: _____

_____

_____

Allergies: _____

Chronic medical conditions/Related surgeries/Ongoing concerns: _____

_____

Is the child currently under treatment? Yes ____ No ____ Details: _____

Are there any limitations on physical activity? Yes ____ No ____

If so, what limitations? _____

Recommendations that may be helpful in the emotional, social or physical development of this child: _____

_____ _____

Health Care Provider Signature Date of Examination

_____ Stamp:

Name of Health Care Provider (*Please print)*