



Manville School District

• 908.231.8500
• www.manvilleschools.org

PHYSICAL EXAMINATION (To Be Completed by a Licensed Healthcare Provider)

NAME _____ Date of Birth: _____ Date of Physical: _____

Height _____ Weight _____ Pulse _____ Blood Pressure _____ Posture _____

Scoliosis _____ Extremities _____ Nutrition _____ Gums _____

Feet _____ Skin _____

Visual Testing: OD: 20 / ___ OS: 20/ ___ OU: 20/ ___

Test used _____

Auditory Testing: Right Ear: _____ Left Ear: _____ Test Used: _____

Neurological _____ Thyroid _____ Other Glands _____

Heart _____ Lungs _____ Abdomen _____

Hernia _____ Genitals _____ LMP (females) _____

TB test: Date _____ Type _____ Read Date: _____ Results: _____

Recent Immunizations: (may attach copy of record): _____

Allergies: Food _____

Medication _____

Previous surgery/hospitalization (type and dates): _____

Medical diagnosis if any: _____

Comments/Recommendations: _____

Restrictions, if any: _____

General Condition: Good _____ Fair _____ Poor _____

This student:

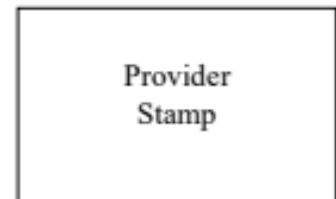
- may
- may not participate in Physical Education and all sports.

Please sign and stamp:

Healthcare Provider Signature: _____

Telephone Number: _____

Date: _____



All students (PreK through Grade 12):
A completed physical and up-to-date proof of immunizations are required upon district enrollment.

NOT A N.J.A.C. SPORTS PHYSICAL EXAMINATION

Every Child, Every Day