

**EWING PUBLIC SCHOOLS**

PHYSICAL EXAMINATION

Name \_\_\_\_\_ School \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_ HR \_\_\_\_\_

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BP \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Eyes: RT \_\_\_\_\_

LT \_\_\_\_\_

Ears: RT \_\_\_\_\_

LT \_\_\_\_\_

Teeth: \_\_\_\_\_

Gums: \_\_\_\_\_

Tonsils: \_\_\_\_\_

Nose: \_\_\_\_\_

Glands: Cervical \_\_\_\_\_

Thyroid \_\_\_\_\_

Heart: \_\_\_\_\_

Lungs: \_\_\_\_\_

Posture/Scoliosis: \_\_\_\_\_

Skin: \_\_\_\_\_

Hernia: \_\_\_\_\_

Speech: \_\_\_\_\_

Restrictions: \_\_\_\_\_

May the child participate in a full school activity program? \_\_\_\_\_

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Date \_\_\_\_\_

Physician Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

