BRANCHBURG TOWNSHIP SCHOOLS
SCHOOL HEALTH SERVICES

PK-5 PHYSICAL EXAMINATION RECORD

-STUDENT INFORMATION-

Name: _____ Age: _____ Date of Birth: _____
Address: _____ City/State/Zip: _____ Home Phone: _____
School: _____Teacher:_____ Grade: _____ Sex: _____
Parent/Guardian s Full Name_____

-PHYSICIAN OR PROVIDER INFORMATION-

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____bpm.
Vision: R 20/____ L 20/ ____ Corrected: Y / N Contacts: Y / N Glasses: Y / N
Hearing: Right ear Normal @ 20dB_____ Left ear Normal @ 20dB_____

Indicators	Normal ? (Circle One)		Abnormal Findings/Comments
Head/Neck	YES	NO	
Eyes/Sclera/Pupils	YES	NO	
Ears	YES	NO	
Nose/Mouth/Throat	YES	NO	
Heart: Murmurs/Rhythms	YES	NO	
Lungs: Auscultation/Percussion	YES	NO	
Chest Contour	YES	NO	
Skin	YES	NO	
Abdomen: Assessment (includes liver, spleen)	YES	NO	
Tanner Stage: Testes/Onset of Menses:	YES	NO	
Neck/Back/Spine: **Range of Motion:**	YES YES	NO NO	
Scoliosis:	YES	NO	
Upper Extremities	YES	NO	
Lower Extremities	YES	NO	
Neurological: **Balance & Coordination:** **Romberg:**	 YES YES	 NO NO	
Heel Walk:	YES	NO	
Tandem Walk:	YES	NO	
Nose Touch:	YES	NO	
Toe Walk:	YES	NO	
Hernia? If yes/possible, please explain)	YES/ Possible	NO	
Existing health conditions:			
Most recent Immunizations/Dates:			
Medications currently in use:			
Recommendations/Limitations/Further examination:			

General Health:_____good_____fair_____poor_____

EXAMINED BY:
Family Physician/Provider_____
School Physician_____

____MD____DO____NP____PA

Physician's/Provider's Stamp:

Physician s/Provider s Name:_____Phone:_____Fax:_____
Address:_____City/State/Zip:_____
Physician's/Provider's Signature:_____ Examination Date:_____

PLEASE ATTACH RECORD OF IMMUNIZATIONS TO PHYSICAL EXAMINATION RECORD