



# Galloway Township Public Schools

101 South Reeds Road

Galloway, NJ 08205

(609) 748-1250

<http://www.gtps.k12.nj.us>

## PHYSICAL EXAMINATION REPORT TO BE COMPLETED BY EXAMINING PHYSICIAN

Student's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_  
Pulse at Rest: \_\_\_\_\_ Pulse after 30 sec exercise: \_\_\_\_\_

	NORMAL	ABNORMAL	COMMENTS
Skin			
Vision			
Hearing			
Nose			
Mouth, Throat			
Neck			
Chest			
Lungs			
Heart			
Abdomen			
Spine/Scoliosis			
Extremities			
Testes			
Physiological Maturation			
Neurological			
Allergies			

Describe any limitations that may inhibit this child's participation in physical education or sports: \_\_\_\_\_

\_\_\_\_\_  
Signature of Examining Physician

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Printed Name of Examining Physician

\_\_\_\_\_  
Phone Number

*"Where Children and Learning Come First"*