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"