

ALEXANDRIA TOWNSHIP SCHOOL DISTRICT
School Physical Form

Name _____ **DOB** _____ **Age** _____

Height _____ Weight _____

Vision R _____ L _____ with Glasses R _____ L _____

Hearing R _____ L _____ Tubes inserted (date) _____

Body systems Please explain positive findings below

Heart _____ Blood Pressure _____

Lungs _____

Abdomen _____ Hernia: Yes _____ No _____

Genitals _____

Nervous System _____

Skin _____

Orthopedic _____

Posture _____

Evidence of Scoliosis _____

Feet _____

Head & Scalp _____

Nose _____

Throat _____

Glands _____

Teeth & Mouth _____

Speech _____

Behavioral _____

Please list any: daily medications/ dose/time

Restrictions, if any _____

Recommendations:

Physician Signature _____ Date _____

Please print name/or stamp _____