Ocean City Public Schools

Physical Examination

(To be completed by the examining physician)

Student's Name: ___________________________________ Examination Date: _________________

Height: _________ Weight: _________ Blood Pressure: ______/_______ Pulse: _____bpm.

Vision: R 20/____ L 20/ ____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

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 (incl. 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	

Most recent immunizations/Dates:
Medications currently being used:
Additional Observations:

-PHYSICIAN INFORMATION-

Name: ________________________________ Phone: ___________________________ Fax: ______________________

Address: _______________________________ City/State/Zip:____

Physician's/Provider's Stamp

Physician's/Provider's Signature: ____

Date___________________________________