



EAST TROY

COMMUNITY SCHOOL DISTRICT

Committed to the Growth & Success of Each Student, Each Year

PHYSICAL EXAMINATION REPORT

Leona Doubek Elementary

Phone: 262-642-6730

Fax: 262-642-6723

Prairie View Elementary

Phone: 262-642-6720

Fax: 262-642-6788

East Troy Middle School

Phone: 262-642-6740

Fax: 262-642-6743

East Troy High School

Phone: 262-642-6760

Fax: 262-642-6776

STUDENT INFORMATION

Last Name: _____ First Name: _____ Date of Birth: _____ M F

Physician's Name: _____ Phone #: _____ Fax #: _____

Physician's Address: _____ City: _____ St: _____ Zip: _____

HEALTH INFORMATION

Height: _____ Weight: _____

Eyes: R: _____ L: _____

Ears: R: _____ L: _____

	Normal	Abnormal	Comments
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Albumin	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional Stability	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Hematocrit	<input type="checkbox"/>	<input type="checkbox"/>	
Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Lymph Glands	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth & Throat	<input type="checkbox"/>	<input type="checkbox"/>	
Neck	<input type="checkbox"/>	<input type="checkbox"/>	
Neuro-Muscular	<input type="checkbox"/>	<input type="checkbox"/>	
Nose	<input type="checkbox"/>	<input type="checkbox"/>	
Posture	<input type="checkbox"/>	<input type="checkbox"/>	
Scalp	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	
Urine	<input type="checkbox"/>	<input type="checkbox"/>	

Activity Limitations: _____

List Medications: _____

Remarks/Recommendations: _____

Summary of Defect(s): _____

PHYSICIAN SIGNATURE

Physician's Signature: _____ Date: _____