PHYSICAL EXAM FORM

Information to be filled out by physician/health care provider:

Name:____________________________

Age: years__________ months__________

Hemoglobin/Hematocrit:	Lead:	Height: Inches	Weight: Lbs.	Blood Pressure:
Urinalysis Results (if indicated):	Vision: L R	Developmental Screening:	Hearing:	
	(These screenings will be done at school for kindergarten students.)			

Does the examination reveal any abnormality?	Normal	Abnormal	Not examined	Describe fully any abnormal findings
General Appearance, Posture, Gait				
Speech / Language Development				
Behavior during examination				
Skin				
Eyes: Extraocular Movements				
Ears: Canal, Tympanic Membrane				
Nose, Mouth, Pharynx, Tonsils				
Teeth				
Heart				
Lungs				
Abdomen (include hernias)				
Genitalia				
Extremities, Feet				
Neurological				
Other:				

Disability (diagnosed)	Treatment

Summary of findings and recommendations:____________________

____

____

Signature of Physician or Health Care Provider   Date

Health Agency Where Examination Completed____________________

HEALTH INFORMATION
for Preschool/Daycare/Schoolage Children

Information to be filled out by parent/guardian/caregiver prior to physical exam:

Child's Information

Child's Full Name:______________________________ Date of Birth:____________

Address:______________________________ Phone:____________

City/State/Zip:______________________________

Center or Program name where child is enrolled:______________________________

Date:______________ Address:______________________________

Physician Information

Name of family physician:______________________________ Phone:____________

Address: ______________________________

Date of last visit:______________ Reason:______________________________

General Health Information

Is the child on any medication?_______ If yes, please list and state purpose______________

____

Has the child been hospitalized?_______ If yes, please explain with dates:______________

____

Has the child had any surgeries?_______ If yes, please list with dates:______________

____

Has the child had a dental exam?______If yes, date of last visit:_______Dentist's name:____________

Address:______________________________ Phone:____________

Illness and Disease Record

Allergy (specify):______________________________

Asthma:______________________________

Chicken Pox (date):______________________________

Convulsive Disorder:______________________________

Repeated Ear Infections:______________________________ Tubes:____________

Pneumonia:______________________________

Frequent Sore Throat:______________________________

Pregnancy/Delivery Complications:______________________________

Prematurity:_____How early?______________________________

Developmental or Learning Delay:______________________________

____

Others:______________________________

____

TURN SHEET OVER FOR PHYSICAL EXAM FORM TO BE FILLED OUT BY PHYSICIAN/ HEALTH CARE PROVIDER.