Clarke Elementary School

PHYSICAL EXAM FORM TO BE COMPLETED BY PHYSICIAN

Child's Name:_____ **DOB:**_____

HEIGHT:_____ **WEIGHT:**_____ **BMI:**_____

Vision: RT_____ **LT**_____ **Pass**_____**Yes / No**_____ **Referral**_____

Medicine taken regularly:_____

Health Conditions:_____

	Normal	Abnormal	Comments - required for abnormal findings
Allergies			
Skin			
HEENT			
Mouth/Dental			**Referal today: Yes: No:**
Cardiovascular			
Respiratory			
Gastrointestinal			
Genitourinary			
Neurological			
Musculoskeletal			
Spinal			
Nutritional			
Speech			
Hearing			
Lead Screen			**(Kindergarten only)**
Immunizations			**Next appt:**

Physical Education/Activity: Full_____ **Limited**_____**Restrictions**_____

Additional Comments/Concerns:_____

_____

Physician's signature:_____ **Date of Exam:**_____

Name of Physician(print):_____

Address:_____**Telephone:**_____