Name______________________ _____ ________   Date of Birth ________ _______ ________________

PHYSICAL ASSESSMENT

To be completed by Physician, Nurse, or School Health professional

REQUIRED

	NL	ABNL	Comments
BP___________			
WT:_______ HT_____			
SKIN: Color, Rash, Swelling, Hair, Nails			
EYES: Conjuctiva, Cornea, Pupils, Extraocular Movement			
EARS: Pinnae, Canals, Tympanic Membrane Appearance, Mobility			
NOSE: Nares, Turbinates			
MOUTH: Tongue, Teeth Oral Mucosa, Tonsils, Pharynx Neck: Thyroid, Range of Motion			
NODES: Cervical, Axillary, Inguinal, Other			
HEART: Rate, Rhythm, S1, S2, Murmur, Femoral Pulses			
LUNGS: Rate, Auscultation, Percussion			
ABDOMEN: Contour, Palpation of Liver, Spleen, Kidney, Mass: Tenderness			
GENITO-URNIARY: Female, External, Male Penis, Meatus, Testes, Hernia			
MUSCULOSKELETAL: Range of Motion, Tenderness, Edema, Clubbing, Spine (Curvature)			
NEUROLOGICAL: Gait, Cerebellar Function, Motor Systems (Strength, Tone) Cranial Nerves (Gross)			
DEVELOPMENTAL			
Gross Motor			
Fine Motor			
Social			
Speech / Language			

SUPPLEMENTAL

	Date	NL	Comments
Hemoglobin			
Hematocrit			
Urinalysis			
Other			

Medications ______________________

____

____

Diet Restrictions

____

____

Special Equipment ______________________

____

Allergies ______________________

General Comments / Recommendations

I have performed a physical assessment on this child on the date indicated, and have arranged for any follow-up that was or is needed.

Signature_____________ Phone_____________Date Signed______________ Date Of Exam______________