PHYSICAL EXAMINATION FORM

(To be Completed by Physician or Designee)

Name of Facility: _____

Address: _____

_____

Phone: _____

Child's Full Name: _____ Age: _____

Height _____ Weight _____

Skin _____

Eyes _____ Nose _____

Ears _____ (L) TM _____

Mouth: Teeth _____ Gingiva _____

Throat _____ Neck _____

Heart _____

Lungs _____

Genitalia _____

Spine and Back _____

Neuromuscular _____

Address _____

Head & Scalp _____

Lymph Nodes _____

(R) TM _____

Palate _____

Chest _____

B.P. _____ Femoral Pulse _____

Abdomen _____

Rectum, Anus _____

Extremities _____

Gait _____

Urinalysis _____

Vision: (R) eye _____ (L) eye _____ Both _____

Hearing: Normal _____ Abnormal _____ Not Tested _____

If Needed: Hemoglobin or Hematocrit _____

Tuberculin screening _____ Sickle Cell screening _____

Development testing _____ Lead screening _____

Other _____

Allergies _____

PHYSICAL EXAMINATION FORM
(Continued)

(To be Completed by Physician or Designee)

SUMMARY OF FINDINGS AND RECOMMENDATIONS

I have examined: _____

He/She is _____ is not _____ physically and emotionally able to participate in your program.

Date of physical examination: _____

_____
(Signature of Physician or Designee)

_____
(Date)

PARENT: Please complete the following.

Diseases child has had: _____

_____

Any special health needs (susceptible to colds, recurrent ear infections, etc.) _____

_____

_____