PHYSICAL EXAMINATION FORM

Child's Name: Last: First: Middle:		Address	Birthdate
Name of Parent or Guardian	Phone	Name of Physician	Phone

PAST HISTORY

	Date	Other	Date
Allergies			
Asthma			
Chicken Pox			
Diabetes			
Measles (Rubeola)		Surgery	
Meningitis			
Mono			
Mumps			
Scarlet Fever		Injuries	
Strep			

	1	2	3	4	5
IMMUNIZATIONS (Month/Day/Year)					
DtaP/DTP					
DT/Td					
Polio OPV/IPV					
MMR					
MR					
Hib					TB
Hepatitis B					Date:
Varicella					Results:
Pneumococcal					
OTHER					

PHYSICAL EXAMINATION

General Appearance				Ht.	**Blood Lead Test Results:**
Posture				Wt.	Comments by Physician:
Nutrition				HEARING	
Skin				Rt.	
Feet				Lt.	
Nose and Throat				VISION	Medicine taken daily:
Eyes and Ears				With glasses	
Tonsils and Glands				Rt.	
Heart and Lungs				Lt.	Conditions that may affect school performance:
Abdomen				No glasses	
Genitals				Rt.	
Urinalysis				Lt.	Restrictions:
Blood Count				Color Problem	
Blood Pressure				Yes No	**PHYSICIAN:**
DENTAL SCREENING					**DATE:**
Condition of teeth:					COMMENTS BY PARENTS:
DENTIST/DOCTOR:					
DATE:					

Rev. 01/08