

Exam Date _____
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Child's Legal Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Parent/Guardian's Name \_\_\_\_\_ Sex:  Male  Female Age \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Elementary School \_\_\_\_\_ Cell Phone / Pager \_\_\_\_\_

\*\*\*\*\* DOCTOR TO COMPLETE FROM HERE DOWN \*\*\*\*\*

Medicine / Food Allergies \_\_\_\_\_ EpiPen Needed?  Yes  No  
 Chronic Medical Problems / Past Surgeries \_\_\_\_\_  
 Medications Taken \_\_\_\_\_

**PHYSICAL EXAM**

Height \_\_\_\_\_ in. ( \_\_\_\_\_ %) (No shoes, nearest 1/4 in.)  
 Weight \_\_\_\_\_ lbs. ( \_\_\_\_\_ %) (Light clothing, nearest 1/4 lb.)  
 B/P \_\_\_\_\_

_____ General Appearance	_____ Nose	_____ Neck	_____ Lungs	_____ Skeletal System
_____ Eyes	_____ Throat	_____ Lymph Nodes	_____ Abdomen	_____ Neuro Muscular
_____ Ears	_____ Teeth	_____ Heart	_____ Genitalia	_____ Skin

Abnormal exam findings \_\_\_\_\_

**IMMUNIZATIONS**

TYPE	DATE (MO/DA/YR)			
DTaP				
Tdap				
POLIO				
HIB				
HEPATITIS B				
MMR				
VARICELLA				
OTHER				

**LABORATORY TESTS**

(optional)  
 Hb. / Hct. \_\_\_\_\_  
 Lead Level \_\_\_\_\_  
 Urine glucose \_\_\_\_\_  
 Urine protein \_\_\_\_\_  
 Urine blood \_\_\_\_\_  
 TB Mantoux \_\_\_\_\_  
 Other \_\_\_\_\_

**SPEECH AND LANGUAGE**

Speech Assessment:  Child has no discernable speech problem  Speech screen not done  
 Child has possible problem with:  None  Articulation  Rhythm  Voice  Language  
 Formal speech evaluation recommended?  No  Yes

**HEARING**

DATE MO/DA/YR	AUDIOMETRY RESULTS (Pass/Fail)		OTHER TESTS (Specify)		REFERRED TO / MANAGED BY
	R	L	R	L	
	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail			

**VISION**

DATE MO/DA/YR	DISTANCE ACUITY Circle one: corrected uncorrected		STRABISMUS		REFERRED TO / MANAGED BY
	R	L	R	L	
	20/	20/			

This child is able to participate in the following:  Classroom and academic activities  Competitive athletics  
 Physical education classes  Contact and collision sports

Describe any concerns, limitations, or recommendations to the school: \_\_\_\_\_

(Office / Doctor's Address Stamp Here)
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Physician's Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_