

Exam Date _____

Child's Legal Name _____
 Parent/Guardian's Name _____
 Address _____

 Elementary School _____

Date of Birth _____
 Sex: Male Female Age _____
 Home Phone _____
 Work Phone _____
 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: _____