

# PHYSICAL EXAMINATION FORM

SECTION A – To be filled in by parent before physical examination

NAME \_\_\_\_\_ SEX: M \_\_\_ F \_\_\_ BIRTHDATE \_\_\_\_\_ GRADE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_

ILLNESS: Check and give approximate date your child had any of the following: \_\_\_\_\_  
 HANDICAPS: Check if your child has any problems with any of the following and give additional comments. \_\_\_\_\_

ALLERGIES					
ADD/ADHD		GERMAN MEASLES		MONONUCLEOSIS	STREP THROAT
ASTHMA		HEARING DIFFICULTY		MUMPS	TUBERCULOSIS
CHICKEN POX		HEART TROUBLE		PHYSICAL HANDICAP	VISION DIFFICULTY
CONSTIPATION		LYME DISEASE		PNEUMONIA	
DIABETES		MIGRAINE HEADACHES		RHEUMATIC FEVER	
EPILEPSY/SEIZURES		MEASLES		SCARLET FEVER	
FREQUENT EAR INFECTION		MENSTRUATION		SPEECH DIFFICULTY	

ADDITIONAL INFORMATION ABOUT YOUR CHILD (include accidents, operations, etc. with dates):  
 \_\_\_\_\_  
 \_\_\_\_\_

SECTION B – To be completed by examining physician (PLEASE INDICATE CONDITION BY CODE AND GIVE DETAILS UNDER POSITIVE FINDINGS.)

CODE \_\_\_\_\_ No defect  
 1 - defect, correction or care not necessary  
 2 - defect, see remarks below

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_

NUTRITION	EARS	NECK	HERNIA
SCALP-SKIN	NOSE	GLANDS	EXTREMITIES
EYES	THROAT	HEART	NERVOUS SYSTEM
DISTANT R 20/ CORR. TO 20/	TEETH - TEMP.	LUNGS	POSTURE
VISION L 20/ CORR. TO 20/	TEETH - PERM.	ABDOMEN	OTHER

POSITIVE FINDINGS: (Include any additional pertinent history)  
 \_\_\_\_\_  
 \_\_\_\_\_

RECOMMENDATIONS: (List any limitation of activity that child should observe.)  
 \_\_\_\_\_  
 \_\_\_\_\_

DTP/DT1	DTP/DT2	DTP/DT3	DTP/DT4	DTP/DT5
OPV/IPV1	OPV/IPV2	OPV/IPV3	OPV/IPV4	OPV/IPV5
MMR1	MMR2	HEP B1	HEP B2	HEP B3
HIB 1	HIB 2	HIB 3	HIB 4	OTHER
Td 1	VARICELLA 1	VARICELLA 2	OTHER	OTHER
LEAD TEST				

MANTOUX TUBERCULIN SKIN TEST DATE \_\_\_\_\_ RESULT \_\_\_\_\_

**OR**

TB RISK ASSESMENT DATE \_\_\_\_\_

Examiner's Signature \_\_\_\_\_  M.D.  P.N.P. DATE \_\_\_\_\_

Printed Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_