

PHYSICAL EXAM FORM

Child's Name: _____
 Date of Birth: _____
 Parent's Name: _____

Pay Source (Please Check): Private Pay
 Medicaid
 Indian Health
 CHP+
 Other Insurance

NOTE: Please complete each item. A completed physical exam on this form is required for enrollment
 And continuing classroom attendance.

BASIC DATA

Ht _____ Wt _____ B/P _____ Pulse _____

Head Circumference _____ (as age appropriate)

Nutritional Assessment Adequate _____ Inadequate _____

Hematocrit _____ or Hemoglobin _____

Actual LAB Value Required

(If done in WIC, Parent is responsible for obtaining date and results)

TB Test (Optional) Results _____ Date _____

Urinalysis (recommended) By dipstick _____ or lab _____

Vision: Acuity: Left: _____ Right: _____

Strabismus Testing: Normal _____ Refer? _____

Hearing: Normal by audiometer? Yes _____ No _____

Speech: Normal by observation? Yes _____ No _____

	Yes	No	Refer?
Head			
Skin			
Eyes			
Ears			
Mouth/Nose/Throat			
Nodes			
Heart			
Lungs			
Abdomen			
Ext. Genitals			
Extremities			
Spine			
Neuro			

Were immunizations given today? Yes _____ No _____ (If yes, please attach copies of immunization record.)

Any illnesses, chronic or disabling problems? _____

Any known allergies? No _____ Yes _____

Any need for medications? No _____ Yes _____

Any special diet recommended by provider? No _____ Yes _____

Does the child seem free of reportable communicable diseases? Yes _____ No _____

Does overall development seem normal for age? Yes _____ No _____

Other comments or recommendations: _____

Name of clinic or physician: _____
(Print)

Signature: _____ Date: _____