CHILD PHYSICAL EXAMINATION

Child's Full Name _____ **Date of Exam** _____

Age _____ **Height** _____ **Weight** _____ **BP** _____ **P** _____

Vision: Eye Correction required ☐ Yes ☐ No ☐ Glasses ☐ Contact Lens

Hearing: ☐ Normal ☐ Abnormal ☐ Not Tested

EENT _____	Heart _____	Genitalia _____
Teeth _____	Abd _____	Rectum, Anus _____
Neck _____	Hernia _____	Neuromuscular _____
Chest _____	Extremities/Skin _____	Urinalysis _____
Lungs _____	Posture/Spine _____	

If needed:

Hemoglobin or Hematocrit _____	Tuberculin screening _____
Sickle Cell screening _____	Development testing _____
Lead screening _____	Other _____

The child is under the care of a physician for the following medical condition(s):

_____

_____

Known allergies: _____

Additional health information: _____

_____

_____

The child is _____ is not ____ physically and/or emotionally able to participate in your program.

_____
Signature of Physician or Designee

_____
Date

PARENT: Please complete the following:

Diseases the child has had _____

_____

Any special health needs _____

_____