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: _____