NAME OF CHILD | **AGE** | **SEX**

Last **First** **Middle** | | **M** ☐ **F** ☐

Significant Medical Conditions (X) (To be compelted by Parent)

	Yes	No	If Yes, Explain
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

Report of Physical Examination (X) (To be completed by Examiner)

	Normal	Abnormal	If Abnormal, Explain
• Height (inches) _____	☐	☐	
• Weight (pounds) _____	☐	☐	
• Pulse (_____)	☐	☐	
• Blood Pressure (_____)	☐	☐	
• Hair/Scalp	☐	☐	
• Skin	☐	☐	
• Eyes—Visual Acuity R__/__ L__/__	☐	☐	
• Eyes—Color Vision	☐	☐	
• Ears—Hearing dB R L	☐	☐	
• Nose and Throat	☐	☐	
• Teeth and Gingiva	☐	☐	
• Lymph Glands	☐	☐	
• Heart—Murmur, etc	☐	☐	
• Lung—Adventious Findings	☐	☐	
• Abdomen	☐	☐	
• Menses	☐	☐	
• Neuromuscular System	☐	☐	
• Extremities	☐	☐	
• Spine (Presence of Scoliosis)	☐	☐	

_____
Date of Examination

_____ _____
Signature of Examiner Print Name of Examiner