____
(Name/Address of Facility)

Physical Exam to be completed by Physician or designee

Child's Name _________________ Medications: List any prescriptions

DOB _________ AGE ________ ________________________

Exam Date ___________ ________________________

Height________ Weight_________ ________________________

BP_________ Allergies_________

Labs: HGB or HCT__________Date tested ____________
Blood Lead level________Date tested ___________ (required)
Urinalysis ___________ Date tested ___________

Sensory screening: Vision: Right eye _______ Left eye __________
Hearing Right ear ______ Left ear _________

Exam Results (N= normal limits)
Oral/teeth ________ Dental referral ___yes ____no
HEENT _________
Neurological_______
Heart________
Lungs________
Abdomen_________
Genitalia _________
Extremities________
Spine/Back __________
Muscles & Joints ___________
Skin/Lymph nodes __________

Health Provider Assessment Statement

Developmental Screening

____Normal ______Abnormal

Referral made _____ yes ______ no

List any known health concerns or medical conditions which the school should be aware:
____
____
____

Date of exam: ___________ ____
Signature of Physician or Designee & Stamp