2020-2021
Physical Examination Form

A licensed physician, nurse practitioner, or physician assistant must complete all sections below.

Child's Name: ________________________ **Child's Date of Birth**: _______________

Child's Grade: _______

Date of examination: ____________

Please attach patient's most recent immunization record ☐

Vitals

Height ________ **Blood Pressure** _____/_____
Weight ________ **Pulse** _________

Hearing and Vision

Hearing: Right __________ Left __________ ☐ Pass ☐Fail

Vision: Right __________ Left __________ ☐ Pass ☐Fail

Corrected: Yes/ No Glasses / Contacts

Examination

Medical	Check one		Comments
	Normal	Abnormal Findings	
Head			
Eyes			
Ears			
Nose/Throat			
Mouth/Teeth/Gums			
Heart			
Chest/Lungs			
Skin			
Abdomen			
Genitalia			
Neurological			

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Musculoskeletal	Check one		Comments
	Normal	Abnormal Findings	
Spinal Screening			
Neck			
Back			
Shoulder/Arm/Elbow			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
Developmental			
Speech/Language			
Social/Emotional			

Identified Special Needs:

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HEALTH CARE PROFESSIONAL'S CERTIFICATION

Health Care Provider's Signature: ______________________________ Date: ___/___/___

Phone Number: ____________________________

Provider's Address: ____