# THE DAYSCHOOL FOR CHILDREN PHYSICAL EXAMINATION FORM
*To be completed by licensed medical physician, nurse practitioner or physician's assistant.*

**Name:**_____ **Sex:**_____ **DOB:**_____

**Date:**_____ **Examiner:**_____

**PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.**

[ ] ADD/ADHD    [ ] Body Piercing/Tattoo    [ ] Emotional    [ ] Physical Disability
[ ] Allergies    [ ] Bone/Spine    [ ] Hearing    [ ] Seizures
[ ] Asthma    [ ] Bowel/Bladder    [ ] Heart    [ ] Speech
[ ] Behavior    [ ] Chicken Pox    [ ] Infections    [ ] Surgery
[ ] Bleeding    [ ] Diabetes    [ ] Kidney    [ ] Vision
[ ] OTHER _____

**Comments:**_____
_____

**Height:**_____ **Weight:**_____ **BP:**_____ **Pulse:**_____

**Vision:**    **Right**_____    **Left**_____

**Hearing:**    **Right**_____    **Left**_____

**Lead Screening:**    **Date Completed**_____    **Results**_____

**Hematocrit/Hemoglobin:**    **Date Completed**_____    **Results**_____

**PPD (Mantoux): Date Placed**_____ **Date Read**_____ **Results (in mm)**_____
**or**
**TB Risk Assessment: Date Completed**_____ **Results**_____

**3.**    **Immunizations** – *Shaded Vaccines Required*

| DTP/Hib 1 / / | DTP/Hib 2 / / | DTP/Hib 3 / / | DTP/ Hib 4 / / | DTaP/Hib 4 / / |
|---|---|---|---|---|
| DTP/DTaP 1 / / | DTP/DTaP 2 / / | DTP/DTaP 3 / / | DTP/DTaP 4 / / | DTP/DTaP 5 / / |
| DT/Td 1 / / | DT/Td 2 / / | DT/Td 3 / / | DT/Td 4 / / | DT/Td 5 / / |
| OPV/IPV 1 / / | OPV/IPV 2 / / | OPV/IPV 3 / / | OPV/IPV 4 / / | OPV/IPV 5 / / |
| MMR 1 / / | MMR 2 / / | HepB 1 / / | HepB 2 / / | HepB 3 / / |
| Hib 1 / / | Hib 2 / / | Hib 3 / / | Hib 4 / / | ///// |
| Hep B 1 (2 dose Version Only) / / | Hep B 2 (2 dose Version Only) / / | Hep B/Hib 1 / / | Hep B/Hib 2 / / | Hep B/Hib 3 / / |
| Varicella 1 / / | Varicella 2 / / | Lyme Vax 1 / / | Lyme Vax 2 / / | Lyme Vax 3 / / |
| Pneumococcal Conjugate 1 / / | Pneumococcal Conjugate 2 / / | Pneumococcal Conjugate 3 / / | Pneumococcal Conjugate 4 / / | ///// |
| Pneumococcal Polysaccharide1 | Pneumococcal Polysaccharide 2 | Hep A 1 / / | Hep A 2 / / | ///// |
| Influenza 1 / / | Influenza 2 / / | Other: / / | Other: / / | ///// |

**CHILD'S NAME**_____

| PHYSICAL EXAMINATION | Check (✓) NORMAL | ABNORMAL | COMMENTS |
|---|---|---|---|
| **General Appearance** | | | |
| **Head/Scalp** | | | |
| **Eyes** | | | |
| **Ears** | | | |
| **Nose/Throat** | | | |
| **Mouth/Teeth/Gums** | | | |
| **Heart** | | | |
| **Chest/Lungs** | | | |
| **Skin** | | | |
| **Abdomen/Hernia** | | | |
| **Genitalia** | | | |
| **Neurological** | | | |
| **Developmental** | | | |
| **Musculoskeletal** | | | |
| **Nutrition** | | | |

**Health Concerns or Special Needs Identified:**_____

_____

## FOR CHRONIC CONDITIONS:

**Please attach care plan, protocols, and/or emergency care plan.**

**Children with life-threatening conditions need an emergency care plan in place.**

**Recommendations or Referrals:**_____

_____

_____

**Examiner's Signature:**_____ **Date:**_____

**Printed Name**_____ **Phone Number:**_____

**Address:**_____