Physical Examination Form

Child's Name: ___________________________ DOB: _____________ Date of Exam: _____________

Dear Provider: We appreciate you taking the time to complete this form in its entirety!

REQUIRED TESTS/SCREENING		
SCREENING RESULTS:		
Development/ Behavior:	Vision: R_______ L _______ Referral: Yes / No	Hearing: R _______ L ______ Referral: Yes / No
Speech:	Strabismus:	Dental: OK / Concerns
PHYSICAL EXAM RESULTS:		
Head:	Eyes:	Ears:
Nose:	Throat:	Neck:
Skin:	Chest:	Lungs:
Abdomen:	Genital:	Bones/Joints:
Nervous System:	Muscular System:	
Height: Weight:	Blood Pressure:	

Allergies/Asthma: ________________________________

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Dietary Concerns/Restrictions: ________________________________

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Physician Specific Concerns/Referrals: ________________________________

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On the basis of my findings as indicated and my knowledge of this child: (S)he is free from contagious and communicable disease, is receiving health care under the approprite schedule set by the AAP and is able to participate in child care/preschool. (S)he has received, or will receive on the above date *date, age-appropriate immunizations in accordance with NC Public Health Law.

Doctor's Name: ________________________________

Doctor's Address: ________________________________

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PLEASE PLACE PROVIDER STAMP HERE!

Doctor's Signature: ________________________________ Date: ________________