

CHILD PHYSICAL EXAM

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Child's Name: Last	First	Parent/Guardian:	
Date of Birth:	Home Phone	Address:	
Child Care Facility Name:			
Child Care Facility Phone	County:	Work Phone:	Cell Phone:

I give my consent for my child's Physician and Child Care Provider to discuss my child's health concerns. _____
Signature Date

Health History and Medical Information Pertinent to Date of Exam _____
Routine child Care and Emergencies: None
Allergies to food or medicine

Length/Height	Weight	Head Circumference	Blood Pressure
____ IN/CM %ILE ____	____ LB/KB %ILE ____	____ IN/CM %ILE ____	____ / ____

PHYSICAL EXAMINATION	NORMAL	ABNORMAL/COMMENTS
HEAD/EARS/EYES/NOSE/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMITIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC/TONE		
DEVELOPMENTAL (E.G. DDST)		

Immunizations	Date	Date	Date	Date	Date	Comments
DTP/DTaP	1	2	3	4	5	
Polio	1	2	3	4		
HIB	1	2	3	4		
HEP B	1	2	3			
HEP A						
Varicella	1	2				
Influenza-yearly						
Other						

NOTE: Ages and number of boosters may vary when immunization start at older ages.

SCREENING TESTS <small>Health care provider determines need and appropriate ages for screening tests</small>	Normal	Abnormal/Comments	Not given at this age
LEAD			
ANEMIA (HGB/HCT)			
URINALYSIS (UA)			
HEARING			
VISION			

Date of Last Dentist's Examination	*SPECIAL INSTRUCTIONS FOR CHILD CARE PROVIDERS
Nutrition: Is a special diet necessary? <input type="checkbox"/> No <input type="checkbox"/> Yes Special Instructions: _____ _____ _____	INFANT NUTRITION: Type of Formula: _____ Age for introduction of solid foods: Meat _____ Fruit _____ Orange juice _____ Cereal _____ Vegetables _____ Table foods _____

HEALTH PROBLEMS OR SPECIAL NEEDS	RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE/DIET (ATTACH ADDITIONAL SHEETS IF NECESSARY)
<input type="checkbox"/> NO PROBLEMS	

MEDICAL CARE PROVIDER:	Next Appointment: (Month/Year)
ADDRESS:	
PHONE:	
	_____ Date Signature of Physician or CRNP