Physical Examination

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Youth Name:_____ Date:_____

Instructions: To be completed by a qualified physician. A person responsible for the child must be present to give the medical history and to hear and discuss recommendations.		
Height:	Weight:	Temperature:
Blood Pressure:	Pulse:	Respiration:

Vision Screening:	Left Eye:	Right Eye:	Both:
Vision Follow-Up Required: Yes No (circle one) Remarks:			

HEAD:	Normal:( ) Abnormal:( ) Remarks:
EYES:	Normal:( ) Abnormal:( ) Remarks:
EAR CANALS: ***TM's:*** ***CERNUM OBSTRUCTED:***	Normal:( ) Red:( ) Normal:( ) Red:( ) Bulging:( ) Retracted:( ) Right: ( ) Left:( )
HEARING:	Normal:( ) Abnormal:( ) Remarks:
NOSE:	Normal:( ) Abnormal:( ) Remarks:
THROAT: ***TONSILS:*** ***ADENOPATHY:***	Normal:( ) Red:( ) Yes: ( ) No: ( ) Hypertrophied:( ) Yes: ( ) No: ( )
ORAL HYGIENE:	Good: ( ) Fair: ( ) Poor: ( )
NECK:	Normal:( ) Abnormal:( ) Remarks:
CHEST:	Normal:( ) Abnormal:( ) Remarks:

LUNGS:	Normal:( ) Abnormal:( ) Remarks
HEART: ***MURMUR:***	Normal:( ) Abnormal:( ) Yes: ( ) No: ( ) Type: Functional: ( ) Nonfunctional: ( )
ABDOMEN:	Normal:( ) Abnormal:( ) Remarks:
GENITALIA:	Normal:( ) Abnormal:( ) Remarks:
HERNIA:	Normal:( ) Abnormal:( ) Remarks:
SPINE: ***SCOLIOSIS:***	Normal:( ) Abnormal:( ) Remarks:
BACK:	Normal:( ) Abnormal:( ) Remarks:
EXTREMITIES:	Normal:( ) Abnormal:( ) Remarks:
SKIN:	Normal:( ) Abnormal:( ) Remarks:

Physical Examination

GENERAL APPEARANCE*:*
GAIT:
POSTURE:
NUTRITIONAL STATUS:
BODY TYPE:
BEHAVIOR:

GROSS NEUROLOGICAL EXAM:	Normal: ( ) Abnormal: ( ) Remarks:
SENSORY ABNORMALITIES:	Yes: ( ) No: ( ) Explain:
MOTOR ABNORMALITIES:	Yes: ( ) No: ( ) Explain:
SPEECH:	Normal: ( ) Abnormal: ( ) Remarks
LEAD EXPOSURE:	Normal: ( ) Abnormal: ( ) N/A: ( ) Remarks:
TB TESTING:	Normal: ( ) Abnormal: ( ) N/A: ( ) Remarks:

DIAGNOSTIC RECOMMENDATIONS OR RISK ASSESSMENTS/SCREENINGS NEEDED: Please Check the Appropriate Recommendations:	
_____ Psychiatric Diagnosis _____ Psychiatric Therapy _____ Psychological Diagnosis _____ Educational Referral _____ Occupational Therapy _____ Physical Therapy _____ Speech Therapy _____ Rehabilitation Referral _____ Surgery _____ HIV/STD risk assessment	_____ Orthopedics _____ ENT _____ Ophthalmology _____ Neurology _____ Dentistry _____ EEG _____ EKG _____ Endocrine Tests _____ Developmental screening _____ Alcohol/Drug abuse screening _____ Other:_____
LABORATORY REQUESTS AND/OR RESULTS:	
IMMUNIZATIONS GIVEN:	

Stamp or Print Physician Name/Address/Phone:

Physician's Signature: _____ Date: _____