



# CHILD'S PHYSICAL EXAMINATION (TO BE COMPLETED BY CHILD'S PHYSICIAN)

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Age _____	Mouth, Teeth _____	Spine/Back _____
Height _____	Gingiva _____	Extremities _____
Weight _____	Palate _____	Neuromuscular _____
Skin _____	Throat _____	Gait _____
Head/Scalp _____	Neck _____	Urinalysis _____
Eyes _____	Chest _____	Vision _____
Nose _____	Heath _____	Left Eye _____
Lymph Nodes _____	B.P. _____	Both Eyes _____
Ears _____	Femoral Pulse _____	Hearing _____
(L) TM _____	Lungs _____	
(R) TM _____	Abdomen _____	

If needed:

Hemoglobin or Hematocrit _____	Developmental Testing _____
Tuberculin Screening _____	Lead Screening _____
Sickle Cell Screening _____	Other _____

Allergies:

\_\_\_\_\_  
\_\_\_\_\_

Summary of findings and recommendations:

I have examined (child's name) \_\_\_\_\_ on (date of exam) \_\_\_\_\_  
and he/she is \_\_\_\_\_ is not \_\_\_\_\_ physically and developmentally able to participate in your program.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_