

CHILD CARE PHYSICAL EXAMINATION

Child's Full Name _____ Date of Exam _____

Age _____ Height _____ Weight _____ BP _____ P _____

Vision: Eye Correction required Yes No Glasses Contact Lens

Hearing: Normal Abnormal Not Tested

EENT _____	Heart _____	Genitalia _____
Teeth _____	Abd _____	Rectum, Anus _____
Neck _____	Hernia _____	Neuromuscular _____
Chest _____	Extremities/Skin _____	Urinalysis _____
Lungs _____	Posture/Spine _____	

If needed:

Hemoglobin or Hematocrit _____	Tuberculin screening _____
Sickle Cell screening _____	Development testing _____
Lead screening _____	Other _____

The child is under the care of a physician for the following medical condition(s):

Known allergies: _____

Additional health information: _____

The child is _____ is not _____ physically and/or emotionally able to participate in your program.

Signature of Physician or Designee

Date

PARENT: Please complete the following:

Diseases the child has had _____

Any special health needs _____

