CHILD HEALTH PHYSICAL FORM

Name of Child:_____

Birth date of child:_____

SECTION A: TO BE COMPLETED BY PARENT BEFORE PHYSICAL EXAMINATION

CHECK IF CHILD HAS PROBLEMS WITH ANY OF THE FOLLOWING: GIVE ADDITIONAL COMMENTS BELOW:

- ❑ Allergies (food, medicine, bee sting, etc.)
- ❑ Constipation/Diarrhea
- ❑ Frequent Colds
- ❑ Hearing Difficulty
- ❑ Seizures
- ❑ Frequent Colds
- ❑ Fainting
- ❑ Speech Difficulty
- ❑ Vision Difficulty
- ❑ Physical Handicap
- ❑ Behavior Problem
- ❑ Asthma

Other:_____

Comments:_____

ADDITIONAL INFORMATION ABOUT YOUR CHILD (Include serious illness, accidents, operations, medications, etc. with dates):

_____
_____
_____
_____

SPECIAL INFORMATION WE SHOULD KNOW ABOUT YOUR CHILD:

_____

Parent/Guardian's Signature: Date:

SECTION B: TO BE COMPLETED BY EXAMING PHYSICIAN/PEDIATRIC NURSE PRACTITIONER

WRITE: X – Within Normal Limits O – See Remarks Below

_____ Scalp, Skin _____ Heart _____ Vision _____ Ear, Nose _____ Lungs

_____ Hearing _____ Throat _____ Abdomen_____ Blood Pressure____ Eyes

_____ Genitalia _____ Teeth _____ Extremities_____ Neck, Glands ____ Nervous System

_____ Height _____ Weight

REMARKS:_____
_____

RECOMMENDATIONS:_____
_____
_____

- ❑ M.D.
- ❑ P.N.P. Examiner's Signature:_____ Date:_____

Examiner's Printed Name_____Telephone_____

Address:_____