PCA

PHYSICAL EXAMINATION FORM

Student Name: _____ DOB: _____

Height: _____ Percentile: _____ B/P: _____ U/A: _____
Weight: _____ Percentile: _____ Pulse: _____ Hgb/Hct: _____

Lead Level 1y/o: _____ Lead Level 2 y/o: _____

Allergies:
_____
_____

	Normal	Abnormal	If abnormal, explain:
Hair/Scalp	☐	☐	
Skin	☐	☐	
Eyes – visual acuity R____ L____	☐	☐	
Eyes – color vision	☐	☐	
Hearing – dB R____L____	☐	☐	
Nose and Throat	☐	☐	
Teeth and Gingiva	☐	☐	
Speech	☐	☐	
Lymph Glands	☐	☐	
Cardiovascular	☐	☐	
Respiratory (asthma, etc.)	☐	☐	
Abdomen	☐	☐	
Gastrointestinal	☐	☐	
Genitalia	☐	☐	
Neurological	☐	☐	
Seizure Disorders	☐	☐	
Muscular System	☐	☐	
Extremities	☐	☐	
Orthopedic (including scoliosis)	☐	☐	
Other	☐	☐	

*Impression of child's present state of health:_____

*Restrictions from sports/activities:_____

*Recommendations regarding:
Medical Needs:_____

Developmental Needs:_____

Family Support:_____

Please provide allergy/asthma/diabetic/epileptic/epi-pen/etc. action plans to parent/guardian.
Please provide most recent immunization record.

Signature of Physician/APRN/PA: _____ Date: _____

Printed name of Physician/APRN/PA: _____ Phone: _____


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