CHILD'S PHYSICAL EXAM

Date of Exam: _____

Child's Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Temperature: _____

Blood Pressure: _____

Immunization Dates: _____

DPT: _____ Measles: _____

Polio: _____ Rubella: _____

Hepatitis: _____ Small Pox: _____

Chicken Pox: _____ Other: _____

Skin: _____

Scalp: _____

Adenoids: _____

Chest: _____

Glands: _____

Heart: _____

Lungs: _____

Abdomen: _____

Secondary sex characteristics: _____

Genitals: _____

Reflexes: _____

Extremities: _____

Posture and Spine: _____

Nutrition: _____

Signs of endocrine imbalance: _____

Menses: _____

Treatment given: _____

_____

_____

Recommendations: _____

_____

_____

_____

Examining Physician Signature: _____

Please print or type: _____

(physicians name)

Address: _____

Phone: _____

DHS: Original
Foster Home: Duplicate