PHYSICAL AND DENTAL EXAMINATION FORM

NAME_____**DOB**_____**EXAM DATE**_____

HEIGHT_____**WEIGHT**_____**BLOOD PRESSURE**_____**REFLEXES**_____

VISION:RIGHT 20/_____**LEFT 20/**_____**IS VISION CORECTION NEEDED**_____

EARS_____**NOSE**_____**THROAT**_____

DENTAL EXAM_____**FURTHER ATTENTION NEEDED?**_____

NECK: LYMPH NODES_____**THYROID**_____

CHEST: APPEARANCE_____**LUNGS**_____**HEART**_____

ABDOMEN: APPEARANCE_____**ENLARGED ORGANS**_____

MASSES_____**HERNIAS**_____

BACK: SPINE(SCOLIOSIS)_____

GENITALIA: DEVELOPMENT_____**PUBIC HAIR**_____**TESTES**_____

AGE OF MENARCHE_____**# OF DAYS IN PERIOD**_____**DAYS BETWEEN**_____

DATE OF LAST PERIOD_____**REGULAR**_____**CRAMPING**_____

EXTREMITIES:_____**JOINT FUNCTION**_____

INDICATION OF SUBSTANCE ABUSE?_____

CONTAGIOUS DISEASES_____

_____

PLEASE LIST ANY OPERATIONS, ACCIDENTS, INJURIES:_____

_____

GIVE DATES OF CHILDHOOD DISEASES:_____

PLEASE LIST ANY FOOD AND DRUG ALLERGIES:_____

_____

RECOMMENDATIONS & COMMENTS:_____

_____

_____

I find no cause to prevent this child from participation in scholastic athletics, recreation, or normal physical activity.

Doctor's Signature_____ Date: _____