

NAME OF CHILD _____ GRADE _____

Last

First

Middle

Significant Medical Conditions (4)

	Yes	No	If Yes, Explain
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical Dependency.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuromuscular Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic Condition.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Illness.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Specify).....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Report of Physical Examination (4)

	Normal	Abnormal	If Abnormal, Explain
* Height (inches)			
* Weight (pounds)			
* Pulse ()			
* Blood Pressure /			
* Hair/Scalp			
* Skin			
* Eyes -- Visual Acuity R__/_L__/_			
* Eyes -- Color Vision			
* Ears -- Hearing dB R L			
* Nose and Throat			
* Teeth and Gingiva			
* Lymph Glands			
* Heart -- Murmur, etc.			
* Lung -- Adventitious Findings			
* Abdomen			
* Genitalia			
* Scoliosis -- Bending Position			
* Neuromuscular System			
* Extremities			
* Social/Learning (see first page section)			

_____ Date of Examination

_____ Signature of Examiner

_____ Print Name of Examiner

_____ Address

_____ Telephone