THE ALEXANDER DAWSON SCHOOL

2024-2025 EARLY CHILDHOOD STUDENT PHYSICAL FORM

To be completed by PHYSICIAN

Student Name _____ **Sex**: M / F **Age** _____ **Grade** _____

Address _____ **Date of Birth** _____

Parent/Guardian _____ **Home Phone** _____ **Cell Phone** _____

Height _____ **Weight** _____ **Pulse** _____ **B/P** _____ **Hearing screening** _____

Vision: R 20/____ L 20/____ **Corrected?:** Y / N **Wears glasses or contacts** (circle one)

INDICATOR	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance		
Head/Neck		
Eyes/Sclera/Pupils		
Ears		
Nose/Mouth/Throat		
Lymph Glands		
Cardiovascular (HR, Rhythm, Murmur)		
Lungs: Auscultation/Percussion		
Skin		
Abdomen (liver, spleen, masses)		
Assessment of physical maturation/Tanner Scale		
Genitalia		
Neck/Back/Spine/Scoliosis?		
Mongolian Spot		
Upper extremities (ROM, strength, stability)		
Lower extremities (ROM, strength, stability)		
Neurological		
Hernia		

Immunizations current? Y / N (please attach vaccination record)

Allergies (food/medication/seasonal/etc): _____

Chronic/Acute medical conditions (ex. asthma, seizures, ADHD, etc):_____

_____

Prescription medications (include dose/frequency & and reason): _____

_____

Restriction or accommodation with physical activity needed? (specify if yes): Y / N

_____

Physician Name & Address (or office stamp):

Physician Signature _____ **Date of Examination** _____