



THE ALEXANDER DAWSON SCHOOL

EARLY CHILDHOOD STUDENT PHYSICAL FORM

To be completed by Health Care Provider

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

Health Care Provider Name & Address (or office stamp):

Health Care Provider Signature _____ Date of Examination _____