Private Physician's Examination

Child's Name _____ Sex _____ Birth Date _____

Address _____

_____

Immunization:	Date	Date	Date	Date	Date	Date	Date
DTP (Diphtheria, Tetanus, Pertussis)							
Td (Tetanus Diphtheria)							
TOPV (Polio Oral Trivalent)							
Measles							
Mumps							
Rubella							
MMR (combined)							
Tetanus Toxoid							
Tuberculin (specify type, results in mm)							
Lead Screening							
Hib							
Varicella							
Other (specify)							

IMPORTANT NOTICE : IT IS REQUIRED THAT DATES OF ALL IMMUNIZATIONS BE LISTED IN FULL (DAY, MONTH, YEAR). ALSO NOTE THAT LEAD PAINT TESTING, HIB, AND VARICELLA ARE NOW MANDATORY.

Medical History (give dates)

Accidents _____ Ear Infections _____ Measles _____ Scarlet Fever _____

Allergy _____ Encephalitis _____ Meningitis _____ Strep. Throat _____

Chicken Pox _____ Rubella _____ Mumps _____ Tonsillitis _____

Congenital Anomaly _____ Heart Disease _____ Operations _____ Tuberculosis _____

Convulsions _____ Hernia _____ Poliomyelitis _____ Whooping Cough _____

Diabetes _____ Kidney Disease _____ Rheumatic Fever _____ Other _____

Pertinent Family Medical History:

Summary of significant treatment programs including current medications and suggestions for modifications to group day care program if indicated:

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In order to ensure a quality standard of complete examination for each child, please record your findings after each item.

(O) = Normal (X) = Abnormal

Examination Date: _____ **Comment** **Treatment**

Age _____ BP _____/_____ Pulse _____

Height _____ Weight _____

Physical Development _____

Nutritional Status _____

Skin _____

Eyes _____ sclera _____ pupils _____
light/distance: right _____ left _____
glasses: _____

Ears _____ canals: right _____ left _____
drums: right _____ left _____

Nose _____ septum _____ turbinates _____

Mouth _____ lips _____ tongue _____ pharynx _____
Teeth _____ gingiva _____

Neck _____ mobility _____ lymph nodes _____ thyroid _____

Throat _____ shape _____ symmetry _____

Lungs _____

Heart _____ rate _____ rhythm _____ murmur _____

Abdomen _____ liver _____ spleen _____ hernias _____

Ano-Genital _____ anus _____ penis _____
testicles: right _____ left _____
labia _____

Spine _____

Lower Extremities _____ range of motion _____
development _____ strength _____

Upper Extremities _____ range of motion _____
development _____ strength _____

Cranial Nerve _____ I-XII _____

Gait _____

Coordination _____

Lab Tests - Hgb/Hct Urinalysis:

Specific Gravity _____ Protein _____ Sugar _____ Cells _____ Bacteria _____

_____

MD Signature Address Date