**Child’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If test were done before this exam, we can use those results. Enter dates if done previously.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TEST** | **DATE** | **RESULT** | **TEST** | **DATE** | **RESULTS** |
| PRESENT AGE |  | Yrs\_\_\_\_Mon\_\_\_\_ | VISION (TYPE OF TEST)  ACUITY, R/L  COMMENTS |  |  |
| HEIGHT |  |  |  |  |
| WEIGHT |  |  |  |  |
| BLOOD PRESSURE |  |  |  |  |
| **LEAD** |  |  |  |  |
| HEARING (Type of Test)  RESULTS, R/L    COMMENTS |  |  | **OTHER TEST** |  |  |
|  |  | TB |  |  |
|  |  | SICKLE CELL |  |  |
|  |  | HBG/HCT |  |  |
|  |  | OTHER |  |  |
| **\*Please attach a copy of all vaccinations to this form.** | Normal for age | Abnormal for age | **Health history & medical information pertinent to routine childcare & diagnosis/treatment in emergency (Describe if any):** | | |
| GENERAL APPEARANCE |  |  |
| POSTURE, GAIT |  |  |
| SPEECH |  |  |
| HEAD |  |  | **Describe all medications & any special diet the child receives & the reason for the medication & special diet. All medications a child receives should be documented in the event the child requires emergency medical care. Attach additional sheets if necessary.** | | |
| SKIN |  |  |
| NOSE, MOUTH, PHARYNX |  |  |
| TEETH |  |  |
| HEART |  |  |
| LUNGS |  |  |
| ABDOMEN (Include Hernia) |  |  | **Child’s allergies (Describe if any):** | | |
| GENNITALIA |  |  |
| BONES. JOINTS, MUSCLES |  |  |
| **NEUROLOGICAL/SOCIAL** |  |  |
| MOTOR SKILLS |  |  |
| COMMUNICATION SKILLS |  |  |
| COGNITIVE |  |  | **List any health problems or special needs & recommended treatment/services. Attach additional sheets if necessary to describe the plan for care that should be followed for the child, including indication of special training required for staff, equipment, & provision for emergencies.** | | |
| SELF-HELP SKILLS |  |  |
| SOCIAL SKILLS |  |  |
| GLANDS (LYMPHATIC/THYROID) |  |  |
| MUSCULAR COORDINATION |  |  |
| **OTHER COMMENTS:** | | | | | |
| **GENERAL STATEMENT OF CHILD’S PHYSICAL STATUS:** | | | | | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Doctor’s Name (Please Print) Phone Number Fax Number  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Practice Name Address  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Doctor’s Signature Date | | | | | |