HEALTH EXAMINATION FORM

 $To \ participate \ in \ sports \ teams, \ please \ complete \ the \ Athletic \ Pre-Participation \ Physical \ Evaluation \ Form \ \underline{in \ addition} \ to \ this \ form$

Child's Last Name	First Name	Middle Name	☐ Female ☐ Male		Date of Birth (Month/Day/Year)	
Child's Address						
City	State		Zip Code			
PHYSICAL EXAMINATION Height Weight BMI Blood Pressure/ DATE OF LAST PHYSICAL EXAM:	NI Abnl	HEENT Dental Abdomen Lymph Nodes Extremities	NI Abnl	Back/Spine Neck Skin Language Lungs	NI Abnl	Genitourinary Cardiovascular Neurological Psychosocial Development Behavioral
If persistent, check all current m ☐ Attention Deficity Hyper Ac ☐ Anxiety ☐ Bleeding disorders ☐ Chronic or recurrent otitis r	ch MAF/Asthma Action edication(s): ☐ Inh tivity Disorder media	Plan) Intermittent aled corticosteriod Diabetes (attace	☐ Mild P Other con th MAF) TS graines ury/disabilit	resistent Metroller Quic	s relief med Speech, Stomach Thyroid Tubercul	hearing or visual impairment n/Intestinal disorder Disease losis, latent infection or disease
Congenital or acquired heart disorder Developmental/learning problem Seizure Other (Specify) Explain all checked items above or on addendum: Dietary Restrictions (please list): Lactose Intolerant Medications (attach MAF if in-school medication is needed) None Yes (please list)						
SCREENING TESTS	Vision		Scoliosis		Tuhe	rculosis
Hearing □ Pure tone audiometry □ OAE □ Normal □ Abnormal Date://	//_ Acuity <i>Right</i>	/ □ No □ Yes		□ Abnormal / <u> / </u>	PPD/ Date: PPD/ Date:	Mantoux placed :/ Mantoux read :/ Abnl □ Not Indicated
RECOMMENDATIONS ☐ Full physical activity ☐ Full ☐ Restrictions (specify) Follow-up Needed ☐ No ☐ No			ASSESSM	ENT Well C	hild 🗆 Di	iagnoses/Problems (explain)
Health Care Provider (print) Facility Name						
Address	C	ity		State		
Telephone		Fax				
Health Care Provider Signature			Date			

PLEASE ATTACH IMMUNIZATION RECORDS