

DELAWARE SCHOOL PHYSICAL EXAMINATION FORM

To be completed by licensed medical physician, nurse practitioner or physician's assistant.

Name: _____ Sex: _____ DOB: _____

Date: _____ Examiner: _____

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

- | | | | |
|--------------------------------------|---|-------------------------------------|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Body Piercing/Tattoo | <input type="checkbox"/> Emotional | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bone/Spine | <input type="checkbox"/> Hearing | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bowel/Bladder | <input type="checkbox"/> Heart | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Infections | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney | <input type="checkbox"/> Vision |
| <input type="checkbox"/> OTHER _____ | | | |

Comments: _____

Height: _____ Weight: _____ BP: _____ Pulse: _____

Vision: Right _____ Left _____

Hearing: Right _____ Left _____

Lead Screening: Date Completed _____ Results _____

Hematocrit/Hemoglobin: Date Completed _____ Results _____

PPD (Mantoux): Date Placed _____ Date Read _____ Results (in mm) _____

or

TB Risk Assessment: Date Completed _____ Results _____

3. Immunizations – Shaded Vaccines Required

DTP/Hib 1 / /	DTP/Hib 2 / /	DTP/Hib 3 / /	DTP/ Hib 4 / /	DTaP/Hib 4 / /
DTaP/DTaP 1 / /	DTaP/DTaP 2 / /	DTaP/DTaP 3 / /	DTaP/DTaP 4 / /	DTaP/DTaP 5 / /
DT/Td 1 / /	DT/Td 2 / /	DT/Td 3 / /	DT/Td 4 / /	DT/Td 5 / /
OPV/IPV 1 / /	OPV/IPV 2 / /	OPV/IPV 3 / /	OPV/IPV 4 / /	OPV/IPV 5 / /
MMR 1 / /	MMR 2 / /	HepB 1 / /	HepB 2 / /	HepB 3 / /
Hib 1 / /	Hib 2 / /	Hib 3 / /	Hib 4 / /	
Hep B 1 (2 dose Version Only) / /	Hep B 2 (2 dose Version Only) / /	Hep B/Hib 1 / /	Hep B/Hib 2 / /	Hep B/Hib 3 / /
Varicella 1 / /	Varicella 2 / /	Lyme Vax 1 / /	Lyme Vax 2 / /	Lyme Vax 3 / /
Pneumococcal Conjugate 1 / /	Pneumococcal Conjugate 2 / /	Pneumococcal Conjugate 3 / /	Pneumococcal Conjugate 4 / /	
Pneumococcal Polysaccharide 1 / /	Pneumococcal Polysaccharide 2 / /	Hep A 1 / /	Hep A 2 / /	
Influenza 1 / /	Influenza 2 / /	Other: / /	Other: / /	

CHILD'S NAME _____

PHYSICAL EXAMINATION	Check (✓)		COMMENTS
	NORMAL	ABNORMAL	
General Appearance			
Head/Scalp			
Eyes			
Ears			
Nose/Throat			
Mouth/Teeth/Gums			
Heart			
Chest/Lungs			
Skin			
Abdomen/Hernia			
Genitalia			
Neurological			
Developmental			
Musculoskeletal			
Nutrition			

Health Concerns or Special Needs Identified: _____

FOR CHRONIC CONDITIONS:

Please attach care plan, protocols, and/or emergency care plan.
Children with life-threatening conditions need an emergency care plan in place.

Recommendations or Referrals: _____

Examiner's Signature: _____ Date: _____

Printed Name _____ Phone Number: _____

Address: _____