Physical Assessment for School Entry

Child's Name_____**Date of Birth**_____**Sex**_____

Physician_____Telephone Number_____

Health History

- Allergies (type)_____

  If yes, is Benadryl required: YES/ NO Is Epi-Pen required: YES/ NO Food Substitution required: YES/ NO
- Current Medications_____
- Nutritional Status_____
- Concerns of child/ parent/ guardian_____

Physical Examination

Height_____Weight_____BP_____Pulse_____Other_____

Hearing: Type of Screen_____Results_____

Vision: Type of Screen_____ Results_____

(0 = No significant findings, 1 = significant findings)

General Appearance_____Integument_____Head/ Neck_____EENT_____

Oral/ Dental_____Heart_____Lungs_____Thorax_____Abdomen_____

GU_____Skeletal_____Musculoskeletal_____Neurological_____

Description of Findings_____

_____

Diagnosis:

Recommendations:

Follow Up:

Full participation in all activities? YES/ NO Restrictions: _____

Attach a copy of all immunization records. Additional information may also be attached.

_____ _____

Date **Signature of Physician**