

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 Problem | <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: _____ | | | |

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) _____

Immunizations - Shaded Vaccines Required

DTP / Hib 1 / /	DTP / Hib 2 / /	DTP / Hib 3 / /	DTP / Hib 4 / /	DTaP / Hib 4 / /
DTP / DTaP 1 / /	DTP / DTaP 2 / /	DTP / DTaP 3 / /	DTP / DTaP 4 / /	DTP / 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) / /	Heb B / Hib 1 / /	Heb B / Hib 2 / /	Heb 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			
Genitalia			
Neurological			
Developmental			
Musculoskeletal			
Nutrition			

Health Problems or Special Needs Identified: _____

FOR CHRONIC CONDITIONS:
Please attach care plan, protocols, and/or emergency care plan

Recommendations or Referrals: _____

Examiner's Signature: _____ Date: _____

Printed Name: _____ Phone Number: _____

Address: _____