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.

☐ ADD/ADHD	☐ Body Piercing/Tattoo	☐ Emotional	☐ Physical Disability
☐ Allergies	☐ Bone Problem	☐ Hearing	☐ Seizures
☐ Asthma	☐ Bowel/Bladder	☐ Heart	☐ Speech
☐ Behavior	☐ Chicken Pox	☐ Infections	☐ Surgery
☐ Bleeding	☐ Diabetes	☐ Kidney	☐ Vision
☐ Other:			

Height:	**Weight:**	**BP:**	**Pulse:**
Vision:	Right	Left	
Hearing:	Right	Left	
Lead Screening (preschool & kindergarten admission only):		Date Completed	Results
Hematocrit/Hemoglobin:	Date Completed	Results	
PPD (Mantoux):	Date Placed	Date Read	Results (in mm)
or			
TB Risk Assessment	Date Completed	Results	

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 (✔) Normal	Abnormal	COMMENTS
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: