

PHYSICIANS PHYSICAL EXAMINATION
Weld County School District RE-5J

Student's Name _____ Date of Birth _____

	NORMAL	ABNORMAL	EXPLANATION
General appearance			
Nutritional state			
Skin			
Eyes			
Ears-Nose-Throat			
Teeth-Mouth			
Lungs			
Heart			
Abdomen			
Genitalia			
Skeletal system			
Muscular system			
Nervous system			

Does this child have a medical diagnosis? yes no If yes, please list: _____

Is this child taking any medication? yes no If yes, please list: _____

Is this child undergoing treatments? yes no If yes, please list: _____

Does child have any known allergies? yes no If yes, please list: _____

Does the child have a history of the following?
 Frequent colds _____ Urinary problems _____ Ear infections _____ Wheezing _____
 Tonsillitis _____ Stomachaches _____ Nosebleeds _____ Headaches _____
 Surgery _____ Head Injury _____ Serious illness or injury _____
 Height: _____ Weight: _____ Vision: Right _____ Left _____ Hearing: Right _____ Left _____

Does this child exhibit normal physical and psychological development for his/her age? yes no If no, please explain: _____

Is this child physically fit to participate in normal physical activities? yes no
 If no, list limitations: _____

State of child's health: _____
 Recommendations/Comments: _____

Date: _____ Physician's Signature: _____
 Address/phone: _____