the Children's Learning Center
380 Washington Ave Roosevelt, NY 11757
516-378-2000 Ext. 280 Fax: 516-377-2081

PEDIATRIC PHYSICAL EXAMINATION FORM

*TO BE COMPLETED BY PRIMARY CARE PHYSICIAN

DATE OF EXAMINATION: _____

CHILD'S NAME: _____ DOB: _____

ADDRESS: _____

MOTHER'S NAME _____ FATHER'S NAME _____

TELEPHONE#: HOME: _____ WORK: _____ CELL: _____

PHYSICAL EXAMINATION

***Immunizations:** **Please attach child's current vaccination records to complete this physical examination.** As a reminder, all immunizations must be up-to-date according to the child's age and grade in order for him/her to attend school. If he/she is exempt from being immunized due to medical reasons, please indicate that below so we may have this on our records. Medical exemption paperwork must be renewed annually along with the physical examinations.

- o **Yes, this child received vaccinations at today's examination; he/she is currently age-appropriately immunized as per NYS Immunization Requirements for School Entrance/Attendance schedule. The following vaccines were administered:**
  _____
- o **Yes, this child is exempt from receiving immunizations since (year) _____ due to medical reasons. Explain:**
  _____

DIAGNOSIS: _____

_____

Hgt: _____ Wgt: _____ VITAL SIGNS: B/P _____ P _____ R _____ T _____ PO2 Sat% _____

Lead Level Results: O**Test Done** O **Lead Elevated >5 mcg/dL**

Gross Dental: normal _ abnormal _ remarks _____

***Vision and Hearing: Please attach child's most current vision exam and hearing test. (circle one) available / not available**

Does the child have any vision problems that may impact his/her educational experience? _____ If yes, please explain:

_____ **Indicate if child wears glasses/contacts:** _____

Does the child have any hearing problems that may impact his/her educational experience? _____ If yes, please explain:

_____ **Indicate if child wears hearing aids:** _____

Current Diet (Regular, Ground, Puree): _____ Liquid consistency (Thin, Nectar/Honey Thickened): _____

Feeding (Pediasure, GT, NGT): _____

Start of Menses (if applicable): _____ (circle one) regular / irregular. Difficulties if any, please explain:
CHILD's NAME: _____ DOB: _____

ALLERGIES (INCLUDE MEDICATION, FOOD, ENVIROMENT):

_____
_____
_____

SEIZURE HISTORY: (DATE OF LAST SEIZURE, TYPE, FREQUENCY, DURATION, WAS DIASTAT EVER ADMINISTERED, OUTCOME)

_____
_____

MEDICATIONS/TREATMENTS AT HOME: (INCLUDE MEDICATION NAME, DOSAGE, FREQUENCY)

_____
_____

MEDICATIONS/TREATMENTS AT SCHOOL: (INCLUDE MEDICATION NAME DOSAGE, FREQUENCY)

_____
_____
_____

- **MEDICATION TO BE ADMINISTERED IN SCHOOL MUST BE ACCOMPANIED BY A DOCTORS ORDER, AS WELL AS SIGNED AND STAMPED BY THE PHYSICIAN**
- **MEDICATION MUST BE SENT IN A CURRENTLY LABELED PHARMACY CONTAINER.**
- **ALL ORDERS SHOULD NOT BE PRESCRIBED ON THIS HEALTH APPRAISAL FORM. IF CHILD NEEDS MEDICATIONS/TREATMENTS DURING SCHOOL HOURS PLEASE COMPLETE PAGE 3. THIS FORM SERVES AS A PRESCRIPTION AND PARENTS AUTHORIZATION FOR OUR NURSES TO ADMINISTER MEDICATIONS/TREATMENTS AS ORDERED DURING SCHOOL HOURS.**

HISTORY: (HOSPITALIZATIONS/SURGERIES/TYPE/DURATION/DATES)

_____
_____
_____

ANNUAL UPDATE:

IN THE PAST YEAR HAS THIS CHILD BEEN HOSPITALIZED? YES / NO

IF YES EXPLAIN: _____
_____

IN THE PAST YEAR HAS THIS CHILD HAD ANY SERIOUS ILLNESS OR INJURY? YES/ NO

IF YES EXPLAIN: _____
_____

REMARKS (ANY ADDITIONAL INFORMATION YOU FEEL MAY BE NECESSARY FOR THE CHILD'S CONTINUED MEDICAL CARE AT SCHOOL): _____
_____

Physician's signature: _____ **Telephone #:** _____ **Date:** _____

Physician's License #: _____ **Physician's NPI #:** _____

********A physician's signature, stamp and date are required to complete this form. ********

Please send this completed examination to our Nursing Office.

Place MD, NP, PA

License & NPI #

Stamp here