PHYSICAL EXAM FORM

P.O. 315364 Tamuning GU, 96931 Tel: 472-2271

CHILD'S INFORMATION:

First Name: ______________________ Last Name: ________________________ Middle Initial: ______

Date of Birth: __________ Male: ☐ Female: ☐ Race/Ethnicity: ____________________

Mailing Address: ________________________ ________________ ______ __________________
P.O. Box/Street City/Village State Zip Code

Home Address: ________________________ ________________ ______ __________________
P.O. Box/Street City/Village State Zip Code

MEDICAL HISTORY:

1. Any history of allergies? ☐ No ☐ Yes, Please Explain: ____________________________
2. Any previous illness? ☐ No ☐ Yes, Please Explain: ____________________________
3. Any hearing problems? ☐ No ☐ Yes, Please Explain: ____________________________
4. Any physical disabilities? ☐ No ☐ Yes, Please Explain: ____________________________

GENERAL INSPECTION:

Head	________	Throat	________	Lungs	________	Extremities	________
Eyes	________	Teeth	________	Abdomen	________	Neurological System	________
Ears	________	Neck	________	Spleen	________		
Nose	________	Chest	________	Genitalia	________		
Mouth	________	Heart	________	Hernia	________		

PHYSICAL EXAMINATION:

Height: ________ Weight: ________ Temp: ________ Pulse: ________ Respiration: ________

Blood Pressure: ________ Vision: Left __________ Right ________

Does this child have any significant problems (physical, social, emotional) which may interfere with his/her school experience?

☐ No ☐ Yes, Please explain: ____

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Additional Comments/Restrictions/Recommendations: ______________________________________

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Date: ______________ Physician Signature: ______________________________

Clinic/Hospital: ____________________________ Print Name: ______________________________