# Shearer Hills Baptist – Early Learning Center
## Physicians Well-Child Check

Parent Name: ________________________________________ Date: ______________________

Childs Name: ____________________________________ Birthdate: _______________________

Sex: _____ Height: _____ Weight: _____ Temperature: _____ Pulse: ______ BP.: __________

Vision; R_____/_____ Corrected/Uncor.________: L_____/_____ Corrected/Uncor.__________

Diet: ____________________________________________________________________________

Sleep Habit:____________________________ Bowel Habit: _____________________________

Allergies: ________________________________________________________________________

Medications: _____________________________________________________________________

Exam:

General: _____________________________________________________________________
Skin: ________________________________________________________________________
Head: ________________________________________________________________________
Eyes: ________________________________________________________________________
Ears: ________________________________________________________________________
Nose: ________________________________________________________________________
Mouth & Teeth: ________________________________________________________________
Neck: ________________________________________________________________________
Chest: _______________________________________________________________________
Heart: _______________________________________________________________________
Abdomen: _____________________________________________________________________
Genitalia: ____________________________________________________________________
Extremities: __________________________________________________________________
Musculoskeletal: _______________________________________________________________
Neuromuscular: ________________________________________________________________

Assessment: ______________________________________________________________________
__________________________________________________________________________________

Immunization Update: _____________________________________________________________

Participation Recommendation:
No Participation in: ______________________________________________________________

Limited Participation in: __________________________________________________________

Requirements: ____________________________________________________________________

Full Participation in: _____________________________________________________________

Physician's Signature: _____________________________________ Date: ____________________

Physician's Name/Group: __________________________________Phone #: ___________________
Address: _______________________________City: ______________________Zip: _____________