CHILD PHYSICAL FORM

PLEASE FILL OUT FORM COMPLETELY AND MAIL:

LSCC 201 North Locust Ave. New Hampton Iowa 50659

CHILD'S NAME:_____SEX_____BIRTH DATE:_____

ACTUAL DATE OF EXAM_____ Doctor's Phone # _____

PLEASE PRINT DOCTOR'S NAME_____(Required)

	Normal	Abnormal	Comments
General Appearance			
Posture			
Speech			
Head			
Skin			
Eyes			
Ears			
Nose, Mouth, Pharynx			
Teeth			
Heart			
Lungs			
Abdomen			
Genitalia			
Bones, Joints, Muscles			
Neurological			
Coordination			
Glands			
Blood Pressure			
Hemoglobin/Hematocrit			

Is this child current for age on required immunizations? YES_____ NO_____

Were any vaccinations given today? (Please list) _____

Is this child on any Medication? YES_____ NO_____ Any Allergies? YES_____ NO_____

Additional Comments: _____

_____

_____

_____

***Must have the Doctor Signature and Actual Date of Exam per Federal Guidelines.**

Signature _____ Date_____