NAME _____ DATE _____

PHYSICAL ASSESSMENT

To be Completed by Physician, Nurse or School Health Professional

REQUIRED

	NL	ABNL	Comments
BP: _____ **WT:** _____ **HT:** _____			
SKIN: Color, Rash, Swelling, Hair, Nails			
EYES: Conjunctiva, Cornea, Pupils, Extraocular Movement			
EARS: Pinnae, Canals; Tympanic Membrane Appearance, Mobility			
NOSE: Nares, Turbinates			
MOUTH: Tongue, Teeth, Oral Mucosa, Tonsils, Pharynx			
NECK: Thyroid, Range of Motion			
NODES: Cervical, Axillary, Inguinal, Other			
HEART: Rate, Rhythm, S1, S2, Murmur, Femoral Pulses			
LUNGS: Rate, Auscultation, Percussion			
ABDOMEN: Contour, Palpation of Liver, Spleen, Kidney; Mass; Tenderness			
GENITO-URINARY: Female External, Male Penis, Meatus, Testes, Hernia			
MUSCULOSKELETAL: Range of Motion, Tenderness, Edema, Clubbing, Spine (Curvature)			
NEUROLOGICAL: Gait, Cerebellar Function, Motor System (Strength, Tone); Cranial Nerves (Gross)			
DEVELOPMENTAL			
Gross Motor			
Fine Motor			
Social			
Speech / Language			

LABORATORY (as indicated)

	Date	NL	Comments
Hemoglobin			
Hematocrit			
Urinalysis			
Other			

Medications _____

Diet Restrictions _____

Special Equipment _____

Allergies _____

General Comments / Recommendations _____

I have performed a physical assessment on this child on the date indicated, and have arranged for any follow-up that was or is needed.

Signature _____ Phone _____ Date Signed _____ Date of Exam _____

Physician, Nurse or School Health Professional