

## DELAWARE SCHOOL PHYSICAL EXAMINATION FORM

*To be completed by licensed medical physician, nurse practitioner or physician's assistant.*

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_

Date: \_\_\_\_\_ Examiner: \_\_\_\_\_

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

- |                                      |   |                                     |  |
|--------------------------------------|---|-------------------------------------|--|
| <input type="checkbox"/> ADD/ADHD    | <input type="checkbox"/> Body Piercing/Tattoo | <input type="checkbox"/> Emotional  | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Allergies   | <input type="checkbox"/> Bone/Spine           | <input type="checkbox"/> Hearing    | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Bowel/Bladder        | <input type="checkbox"/> Heart      | <input type="checkbox"/> Speech              |
| <input type="checkbox"/> Behavior    | <input type="checkbox"/> Chicken Pox          | <input type="checkbox"/> Infections | <input type="checkbox"/> Surgery             |
| <input type="checkbox"/> Bleeding    | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Kidney     | <input type="checkbox"/> Vision              |
| <input type="checkbox"/> OTHER _____ |   |                                     |  |

Comments: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_

Vision: Right \_\_\_\_\_ Left \_\_\_\_\_

Hearing: Right \_\_\_\_\_ Left \_\_\_\_\_

Lead Screening: Date Completed \_\_\_\_\_ Results \_\_\_\_\_

Hematocrit/Hemoglobin: Date Completed \_\_\_\_\_ Results \_\_\_\_\_

PPD (Mantoux): Date Placed \_\_\_\_\_ Date Read \_\_\_\_\_ Results (in mm) \_\_\_\_\_

or

TB Risk Assessment: Date Completed \_\_\_\_\_ Results \_\_\_\_\_

### 3. Immunizations – Shaded Vaccines Required

DTP/Hib 1 / /	DTP/Hib 2 / /	DTP/Hib 3 / /	DTP/ Hib 4 / /	DTaP/Hib 4 / /
DTP/DTaP 1 / /	DTP/DTaP 2 / /	DTP/DTaP 3 / /	DTP/DTaP 4 / /	DTP/DTaP 5 / /
DT/Td 1 / /	DT/Td 2 / /	DT/Td 3 / /	DT/Td 4 / /	DT/Td 5 / /
OPV/IPV 1 / /	OPV/IPV 2 / /	OPV/IPV 3 / /	OPV/IPV 4 / /	OPV/IPV 5 / /
MMR 1 / /	MMR 2 / /	HepB 1 / /	HepB 2 / /	HepB 3 / /
Hib 1 / /	Hib 2 / /	Hib 3 / /	Hib 4 / /	
Hep B 1 (2 dose Version Only) / /	Hep B 2 (2 dose Version Only) / /	Hep B/Hib 1 / /	Hep B/Hib 2 / /	Hep B/Hib 3 / /
Varicella 1 / /	Varicella 2 / /	Lyme Vax 1 / /	Lyme Vax 2 / /	Lyme Vax 3 / /
Pneumococcal Conjugate 1 / /	Pneumococcal Conjugate 2 / /	Pneumococcal Conjugate 3 / /	Pneumococcal Conjugate 4 / /	
Pneumococcal Polysaccharide 1 / /	Pneumococcal Polysaccharide 2 / /	Hep A 1 / /	Hep A 2 / /	
Influenza 1 / /	Influenza 2 / /	Other: / /	Other: / /	

CHILD'S NAME \_\_\_\_\_

PHYSICAL EXAMINATION	Check (✓)		COMMENTS
	NORMAL	ABNORMAL	
General Appearance			
Head/Scalp			
Eyes			
Ears			
Nose/Throat			
Mouth/Teeth/Gums			
Heart			
Chest/Lungs			
Skin			
Abdomen/Hernia			
Genitalia			
Neurological			
Developmental			
Musculoskeletal			
Nutrition			

Health Concerns or Special Needs Identified: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FOR CHRONIC CONDITIONS:**

Please attach care plan, protocols, and/or emergency care plan.

Children with life-threatening conditions need an emergency care plan in place.

Recommendations or Referrals: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Examiner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_