

**PHYSICAL EXAMINATION
SUNFLOWER CHILDCARE/PRESCHOOL
(to be completed by physician or designee)**

Child's Full Name		Birth Date
Age	Height	Weight
Skin		Head & Scalp
Eyes	Nose	Lymph Nodes
Vision (R) eye	(L) eye	Both
Ears	(L)TM	(R)TM
Hearing: Normal	Abnormal	Not Tested
Mouth: Teeth	Gingiva	Palate
Throat	Neck	Chest
Heart		B.P. Femoral Pulse
Lungs		Abdomen
Genitalia		Rectum, Anus
Spine & Back		Extremities
Neuromuscular		Gait

If Needed:

Hemoglobin/Hematocrit	<input type="checkbox"/>	Tuberculin screening
Sickle Cell Screening	<input type="checkbox"/>	Development Testing
Lead Screening	<input type="checkbox"/>	Other

Allergies:

Summary of Findings:

I have examined _____. He/She is _____ is not _____ physically and emotionally able to participate in your program.

Additional comments:

Doctor or Designee: _____ Date of Exam: _____

