Children's Sanctuary, Inc.

CLIENT PHYSICAL EXAMINATION

CLIENT NAME: ______________________ **DOB:** __________ **Date of Exam:** __________
DOCTOR'S NAME: ______________________
Office Address: ______________________ **Phone:** __________

SECTION A – PHYSICAL EXAM

Weight:		Height:		Temp:		Resp. Pulse:		Blood Pressure:	

CATEGORY	WNL	COMMENTS	CATEGORY	WNL	COMMENTS	CATEGORY	WNL	COMMENTS
Development			Posture/ Spine			Nose		
Scalp			Orthopedic			Teeth		
Head			Nervous system			Heart		
Ears			Reflexes			Extremities		
Tonsils			Nutrition			Abdomen		
Glands			Skin			Genitals		
Lungs			Eyes			Rectal		

Other (specify) : ______________________
Chief Complaint : ______________________
Present Illness : ______________________

SECTION B - REVIEW OF PATIENT'S HISTORY

CATEGORY	COMMENTS	CATEGORY	COMMENTS
General Health		Allergies	
Injuries		Surgeries	
Previous Medication		Current Medication	
Skin		Head	
ENT		Respiratory	
Cardio-Vascular		Gastro-Intestinal	
Genito-Urinary		Female Repro	
Nervous		Musculo-Skeletal	

Assessment of Emotional Status : ______________________

Menses History : ______________________

SECTION C - PHYSICIAN'S REMARKS AND RECOMMENDATIONS

Does the child have any medical condition that could be harmful to others? ___ YES (Explain below): ____ NO ____

Is the child physically able to participate in school recreational activities? ____ NO (Explain below): ____ YES: ____

______________________ ______________
Signature of Examining Physician **Date**

THE OVER THE COUNTER MEDICATION APPROVAL FORM MUST BE COMPLETED ANNUALLY WITH THE PHYSICAL.