# SOUTHERN PUBLIC SCHOOL PHYSICAL EVALUATION REPORT FORM

Name:_____ Date of Birth:_____

School Year:_____ Date:_____

## FORM TO BE COMPLETED BY YOUR FAMILY PHYSICIAN

| | Normal | Abnormal | Describe |
|---|---|---|---|
| Skin | | | |
| Head | | | |
| Eye grounds | | | |
| Ears | | | |
| Nose | | | |
| Mouth and Throat | | | |
| Scalp | | | |
| Neck | | | |
| Thyroid | | | |
| Lymph Nodes | | | |
| Heart | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitalia | | | |
| (include Hernia) | | | |
| Back and Spine | | | |
| Extremities | | | |
| Neurological | | | |
| Psychiatric | | | |
| Epilepsy | | | |
| Diabetes | | | |
| Scoliosis | | | |
| Other | | | |

TB Skin Test _____

Urinalysis_____ Hemoglobin (optional)_____

Blood Pressure_____ Height_____ Weight_____

Does this child have any special or unusual condition? _____

_____

COMMENTS/RECOMMENDATIONS:_____

_____

_____ NO FURTHER HEARING SCREENING REQUIRED BY SCHOOL FOR THIS YEAR.

___NO FURTHER HT./WT./BMI SCREENING REQUIRED BY SCHOOL FOR THIS YEAR

Evaluation performed by: _____ __M.D. __P.A. _A.P.R.N

Office Phone number: ___ ___ ___-___ ___ ___-___ ___ ___ ___