



Immunization / Health Screening Form (page 2/2)

Physical Exam:

Date of Exam: Wt Ht BMI Temp ° Pulse Resp BP

General Appearance:

Vision: WNL [] Abnormal []

Comment:

Glasses/contacts:

Hearing: WNL [] Abnormal []

Comment:

Hearing aid:

Musculoskeletal: WNL [] Abnormal []

Comment:

Scoliosis:

Comment:

Neck/Thyroid: WNL [] Abnormal []

Comment:

Lymph Nodes: WNL [] Abnormal []

Comment:

Chest/Lungs: WNL [] Abnormal []

Comment:

Heart/Murmur: WNL [] Abnormal []

Comment:

GI/Abdomen/Hernia: WNL [] Abnormal []

Comment:

Genitalia: WNL [] Abnormal []

Comment:

Tanner Stage:

Comment:

Neurological: WNL [] Abnormal []

Comment:

Psychosocial: WNL [] Abnormal []

Comment:

Skin: WNL [] Abnormal []

Comment:

HEENT: WNL [] Abnormal []

Comment:

Conditions requiring treatment:

Activity Restrictions:

School [] Sports [] Other [] No Restrictions []

Restrictions:

Clearance criteria:

Practitioner Contact Information:

Name:

Email:

Work Phone:

Work Fax:

Practice Address:

Address line 2:

Address line 3:

City:

State:

Province:

Region:

Postal Code:

Country:

Practitioner Signature: _____

Date : _____