C H I L D C A R E C E N T E R

P H Y S I C A L E X A M I N A T I O N

STUDENT’S NAME BIRTHDATE

CENTER

PARENT’S NAME

ADDRESS HOME PHONE

PARENT PRESENT AT EXAMINATION

PHYSICAL EXAMINATION

Required by Municipal Ordinance 16.55.390G. Health in child care facilities.

|  |
| --- |
| HEIGHT |
| WEIGHT |
| VISION |
| COLOR VISION |
| ROUTINE MEDICATION: |
|  |
|  |
|  |
| COMMENTS: |
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|  |
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| --- |
| **ITEM RESULTS** |
| 1. EYE DISESE |
| 2. EAR DISEASE |
| 3. NOSE AND THROAT |
| 4. MOUTH |
| 5. TEETH |
| 6. LYMPH NODE |
| 7. HEART |
| 8. LUNGS |
| 9. ABDOMEN-HERNIA |
| 10. GENITALS |
| 11. ORTHOPEDIC (INC. GAIT) |
| 12. NERVOUS SYSTEM |
| 13. SKIN |
| 14. NUTRITION |
| 15. ENDOCRINE |
| 16. OTHER |
| 17. POSITIVE FINDINGS |

Able to participate in usual group activities?

yes or no

DATE OF EXAM:

SIGNED:

(Medical Examiner)mh

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