Report of Physical Examination

14900 Bogle Drive, Suite 200 • Chantilly, VA 20151-1652 • 703-817-9890 • FAX 703-817-9860 • www.fcsva.org

Child's Name: _____ Birthdate: _____

Date of Examination: _____ Physician's Name: _____

Please evaluate and document the following during the medical examination

1. **Vitals:** Height: _____ Weight: _____ B/P: _____

Growth and development: ☐ Normal ☐ Abnormal please describe below:

2. **Vision**: ☐ Normal ☐ Abnormal please describe below:

3. **Hearing**: ☐ Normal ☐ Abnormal please describe below:

4. **Nutritional Status**: ☐ Normal ☐ Overweight ☐ Underweight ☐ Malnourished

List Nutritional Needs/Recommendations/Diet Restrictions Below:

5. **Chronic Conditions or Handicaps**: ☐ No ☐ Yes please describe below:

6. **Allergies:** ☐ No ☐ Yes please describe below:

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7. **TB/Communicable Disease**: Is patient clear of communicable disease/tuberculosis:

☐ Yes ☐ No, please describe concerns and treatment below:

8. **Normal Evaluation**: ☐ Yes ☐ No, please describe concerns below:

9. **Recommendations**: (Restricted/permitted activities, follow up, etc) describe concerns below:

10. **Immunizations**: Any Immunizations given in past 13 months? ☐ No ☐ Yes please list below:

Immunization	Date Given

_____ _____ _____
Signature Licensed Provider Print Licensed Provider Date

Address_____
Phone Number:_____

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