PHYSICAL ASSESSMENT

To be Completed by Physician, or Advanced Practice Nurse

NAME OF STUDENT_____ **BIRTHDATE** _____

REQUIRED					
	NL	**ABNL**	**COMMENTS**		
BP: _____ **WT**: _____**HT**: _____					Medications
SKIN: Color, Rash, Swelling, Hair, Nails					
EYES: Conjunctiva, Cornea, Pupils, Extraocular Movement					
EARS: Pinnae, Canals; Tympanic Membrane Appearance, Mobility					
NOSE: Nares, Turbinates					
MOUTH: Tongue, Teeth, Oral Mucosa, Tonsils, Pharynx					
NECK: Thyroid, Range of Motion					
NODES: Cervical, Axillary, Inguinal, Other					Diet Restrictions
HEART: Rate, Rhythm, S1. S2. Murmur, Femoral Pulses					
LUNGS: Rate, Auscultation, Percussion					Special Equipment
ABDOMEN: Contour, Palpation of Liver, Spleen, Kidney; Mass; Tenderness					
GENITO-URINARY: Female External, Male Penis, Meatus, Testes, Hernia					Allergies
MUSCULOSKETAL: Range of Motion, Tenderness, Edema, Clubbing, Spine (Curvature)					
NEUROLOGICAL: Gait, Cerebellar Function, MotorSystem (Strength, Tone); Cranial Nerves (Gross)					
DEVELOPMENTAL					General Comments/Recommendations
Gross Motor					
Fine Motor					
Social					
Speech/ Language					

I have performed a physical assessment on this child on the date indicated and have arranged for any follow-up that was or is needed.

Signature _____Date Signed _____ Date of Exam _____

(Physician or Advanced Practice Nurse)