PHYSICAL ASSESSMENT

To be Completed by Physician, or Advanced Practice Nurse

NAME OF STUDENT _____ **BIRTHDATE** _____

REQUIRED

	NL	ABNL	COMMENTS
BP: _____ **WT:** _____ **HT:** _____			
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			
HEART: Rate, Rhythm, S1. S2. Murmur, Femoral Pulses			
LUNGS: Rate, Auscultation, Percussion			
ABDOMEN: Contour, Palpation of Liver, Spleen, Kidney; Mass; Tenderness			
GENITO-URINARY: Female External, Male Penis, Meatus, Testes, Hernia			
MUSCULOSKETAL: Range of Motion, Tenderness, Edema, Clubbing, Spine (Curvature)			
NEUROLOGICAL: Gait, Cerebellar Function, MotorSystem (Strength, Tone); Cranial Nerves (Gross)			
DEVELOPMENTAL			
Gross Motor			
Fine Motor			
Social			
Speech/ Language			

Medications

Diet Restrictions

Special Equipment

Allergies

General Comments/Recommendations

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)