

PHYSICAL EXAM FORM

**HMS SCHOOL FOR CHILDREN
WITH CEREBRAL PALSY**

4400 Baltimore Avenue Philadelphia, PA 19104
Phone: 215-222-2566 Fax: 215-662-5159



STUDENT'S NAME _____ **D.O.B.** ___/___/___

SEX ___ **SCHOOL YEAR** _____ **DATE OF EXAM** ___/___/___

INTERIM HISTORY (GENERAL HEALTH/MENTAL HEALTH)

DIET/NUTRITION _____

MEDICATIONS _____

ALLERGIES _____

EQUIPMENT _____

ANTICIPATORY GUIDANCE _____

HT ____ WT ____ BMI ____ TEMP ____ PULSE ____ RR ____ B/P ____/____

HGB ____ UA ____ Pb TEST → RESULTS _____ DATE ____/____/____

SICKLE CELL SCREENING → RESULTS _____ DATE ____/____/____

PPD → RESULTS _____ DATE ____/____/____

PHYSICAL ASSESSMENT (√ IF NORMAL-----DESCRIBE ABNORMAL FINDINGS)

SKIN: _____

HEAD: _____

EYES: _____

EARS: _____

NOSE: _____

MOUTH/DENTITION: _____

THROAT: _____

NECK: _____

NODES: _____

HEART: _____

LUNGS: _____

ABDOMEN: _____

GU: _____ MENSES: _____

GI: _____

TANNER: _____

SPINE: _____

EXTREMITIES: _____

NEURO: _____

MENTAL HEALTH: _____

IMMUNIZATIONS

VACCINE NAME	DATE	DATE	DATE	DATE	DATE	DATE
DTaP/DT/Td						
POLIO						
Hib						
Hepatitis B						
Hepatitis A						
Varicella						
MMR						
Pneumococcal PCV 7						
Pneumococcal PPV 23						
Meningococcal MCV 4						
Meningococcal MPSV 4						
HPV						
Tdap						
Influenza						
Other						

RECOMMENDATIONS FOR FOLLOW UP CARE _____

Date of Next Appointment ___/___/___

Provider's Name _____ / _____
PRINT SIGNATURE

Address _____

Phone _____ **Fax** _____