HS/EHS PHYSICAL RECORD

Please complete all areas on the front and back. Thank you.

Child's Name	Gender: ☐ M ☐ F	DOB
Please list any current illness/diseases/medication		

***Physical Exam DUE: _____**

TO BE COMPLETED BY PHYSICIAN (Per the EPSDT/Health Tracks Schedule)		
Test	***Results***	***Date***
Present Age	Years Months	
Height (no shoes, to nearest 1/8")		
Weight (light clothing/nearest ¼ lb.)		
Blood Pressure/Temp/Pulse		
Hematocrit or Hemoglobin		
Immunizations administered/up to date		
Lead		
Urinalysis		

_____ At this time I don't feel it is necessary to complete a lead/hemoglobin/urine test on the above named child

Physician must initial

SENSORY SCREENINGS	**Results/Comments**	**Date**
Hearing		
Vision		

OPTIONAL SCREENINGS/IF WARRANTED		
Test	**Results**	**Date**
1. TB		
2. Sickle Cell		
3. Ova & Parasites		
4. Other		

FLIP OVER →

PHYSICAL EXAMINATION / ASSESSMENT – COMPLETE & RETURN TO HS				
	Normal for Age	Abnormal	Not Evaluated	Findings, Treatments, & Recommendations
1. General Appearance				
2. Posture, gait				
3. Speech				
4. Head				
5. Skin				
6. Eyes a. External Aspects				
b. Optic Fundoscopic				
c. Cover Test				
7. Ears a. External/Canals				
b. Tympanic/Membranes				
8. Nose, Mouth, Pharynx				
9. Teeth/Gums/Mucosa Dental/oral exam completed (0-3)				
10. Heart				
11. Lungs				
12. Abdomen (include hernia)				
13. Genitalia				
14. Bones, joints, muscles				
15. Neurological / Social				
a. Gross Motor				
b. Fine Motor				
c. Communication Skills				
d. Cognitive				
e. Self-Help Skills				
f. Social Skills				
16. Glands (lymphatic/thyroid)				
17. Muscular Coordination				
18. Other				
General statement on child's physical status and/or recommendations:				

Physician's Signature	Date	Stamp or Print Address Here

Please return completed form to:

MSU Child Development Programs
Attn: Health Coordinator
330 Third Street NE Mayville, ND 58257