

Springfield College
Child Development Center

715 Wilbraham Road, Springfield, MA 01109
(413) 788-2451



Private Physician's Examination

*Your physician is welcome to substitute his/her school physical/immunization form. In order to ensure a quality standard of complete examination for each school child, please record your findings after each item:

(O) normal (X) abnormal

Name of Child: _____

Physical Development: _____

Nutritional Status: _____

Skin: _____

Eyes: _____ Sclera: _____ Pupils: _____
Light and Distance: _____ r _____ l _____

Glasses: _____

Ears: _____ Canals: _____ r _____ l _____

Nose: _____ Septum: _____ Turbinates: _____

Mouth: _____ Lips: _____ Tongue: _____ Pharynx: _____

Teeth: _____ Gingiva: _____

Neck: _____ Mobility: _____ Lymph Nodes: _____ Thyroid: _____

Throat: _____ Shape: _____ Symmetry: _____ Lungs: _____

Heart: _____ Rate: _____ Rhythm: _____ Murmur: _____

Abdomen: _____ Liver: _____ Spleen: _____ Hernia: _____

Ano-Genital: _____ Anus: _____ Penis: _____

Testicles: _____ r _____ l _____

Labia: _____

Spine: _____

Lower Extremities: _____
Development: _____

Range of Motion: _____
Strength: _____

Upper Extremities: _____
Development: _____

Range of Motion: _____
Strength: _____

Cranial Nerve: _____

I-XII: _____

Gait: _____

Coordination: _____

Lab Tests

Hgb/Het

Urinalysis

Specific Gravity: _____ Protein: _____ Sugar: _____ Cells: _____

Doctor's Signature

Address

Date of Examination