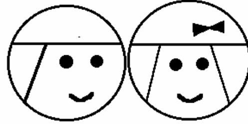

Junior Academy Childrens Centers

Physical Form

Name: ____________________________ Date: ___________ Age: ____ Birthdate: ______________

Address: ____ Phone Number: ______________

Parent/Guardian: ____

Immunization Record: ________ on file with child care center _________ copy attached to physical

Recent exposures to communicable diseases (TB, hepatitis, etc.) _____________________________
Chronic Illnesses: ____
Chronic Medications: ____
Limitations (physical, environmental, medicines): ____

Allergies (food, environmental, medicines): ____
____

Physical Exam:	Normal	Abnormal or comments	Initials
1. Head, eyes, ears, nose, throat			
2. Mouth, teeth			
3. Neck			
4. Cardiovascular			
5. Chest and lungs			
6. Abdomen			
7. Skin			
8. Musculoskeletal: range of motion, strength			
9. Neurological and development level for age			

Comments or concerns: ____

____

_________________ ______________________________ ______________________________
(Date) (Print – Primary Medical Provider) (Signature – Primary Medical Provider)

____
(Address of Provider) (Phone Number)