

EARLY CHILDHOOD PROGRAMS PHYSICAL EXAMINATION FORM

Central Nebraska Community Action Partnership (CNCAP)

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CHILD'S NAME	M	F	RACE	DOB	AGE
PARENT'S NAME	Primary Physician			Last well child check	
ADDRESS	Medicaid #			Private Insurance	

TEST	RESULTS	TEST	RESULTS
Height		%	IMMS Given/Immunization Status
Weight		%	Hemoglobin
BMI		%	Blood Lead
Vitals- Blood Pressure/Temp/Pulse/Resp.		Hearing	<u>Left</u> <u>Right</u>
Vision	<u>Left</u> <u>Right</u> <u>Both</u>	UA	<u>pH</u> <u>Glucose</u> <u>Ketones</u> <u>Other</u>

Nurse Signature: _____

PHYSICAL EXAMINATION/ASSESSMENT (to be completed by Medical Provider)				Past Medical History:
	Normal	Abnormal	Not evaluated	
GENERAL APPEARANCE				Comments:
POSTURE, GAIT				
SPEECH				
HEAD				
SKIN/GLANDS				
EYES <u>External Aspects</u> <u>Optic Fundiscopic</u>				
EARS <u>External & Canals</u> <u>Tympanic Membranes</u>				
NOSE, MOUTH, PHARYNX				
TEETH/FLUORIDE				
HEART				
LUNGS				
ABDOMEN (include hernia)				
GENITALIA				
BONES, JOINTS, MUSCLES				
NEUROLOGICAL				
<u>Cerebral</u>				
<u>Cranial</u>				
<u>Cerebellar</u>				
<u>Motor</u> <u>Reflexes</u>				

FINDINGS, TREATMENTS, AND RECOMMENDATIONS		
Finding/Diagnosis	Treatment Plan	Referrals
1.		
2.		
3.		

PLEASE ATTACH A COPY OF CURRENT IMMUNIZATION RECORD

Payment Source: [] Medicaid [] Private Insurance [] CNCAP Early Childhood Programs [] Other