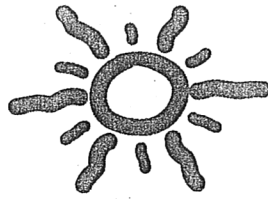


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CHILD'S NAME _____ AGE _____

Height _____ Weight _____

Eyes _____ Lymph Nodes _____

Teeth _____ Throat _____

Heart _____ B.P. _____ Femoral Pulse _____

Spine and Back _____ Gait _____

Urinalysis (if needed) _____ Hemoglobin _____

Vision- R Eye _____ L Eye _____ Both _____

Hearing- Normal _____ Abnormal _____ Not tested _____

Tuberculin Screening (if needed) _____

Developmental Screening (if needed) _____

Allergies _____

Medications _____

Restrictive Conditions: _____

Summary of Findings and Recommendations:
_____ (Name) _____ (is) _____ (is not) physical and

emotionally able to participate in your program.

Additional Comments: _____

IMMUNIZATIONS: Are _____ Are Not _____ complete for age.

Signature of Physician _____

Date of Examination _____