



FAMILY PHYSICIAN REPORT

PLEASE INCLUDE A COPY OF THIS CHILD'S IMMUNIZATION RECORDS

NAME: _____ D.O.B: _____

Height: _____ Weight: _____

Eyes: _____ Genito-Urinary: _____

Ears: _____ Urinalysis: _____

Nose: _____ Structural: _____

Teeth: _____ Orthopedic: _____

Tonsils: _____ Scoliosis: _____

Lymph Nodes: _____ Feet: _____

Thyroid: _____ Skin: _____

Lungs: _____ Epilepsy: _____

Heart: _____ Nervous System: _____

Blood Pressure: _____ Speech: _____

Abdomen: _____ Nutrition: _____

Hernia: _____

Other: _____

Any Known Allergies: _____

Any Medications: _____

Is physical development appropriate to age? Yes _____ No _____

Full physical activity? Yes _____ No _____

If NO for either of above please explain why: _____

Doctor's Signature: _____ Date: _____