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 Left Right	
Vision Left Right Both			UA pH Glucose Ketones Other	

Nurse Signature:

PHYSICAL EXAMINATION/ASSESSMENT
(to be completed by Medical Provider)

	Normal	Abnormal	Not evaluated
GENERAL APPEARANCE			
POSTURE, GAIT			
SPEECH			
HEAD			
SKIN/GLANDS			
EYES External Aspects			
Optic Fundiscopic			
EARS External & Canals			
Tympanic Membranes			
NOSE, MOUTH, PHARYNX			
TEETH/FLUORIDE			
HEART			
LUNGS			
ABDOMEN (include hernia)			
GENITALIA			
BONES, JOINTS, MUSCLES			
NEUROLOGICAL			
Cerebral			
Cranial			
Cerebellar			
Motor			
Reflexes			

Past Medical History:

Comments:

Name of Medical Provider _____

Signature_____ Title_____

Date of exam_____

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