Identifying information of child patient is on front of form.

Allergies ____NKA  Please List: ________________________________
Current Meds/Vitamins: ________________________________
Height: ______  Weight: ______  BP (age 3 and up): ______  Pulse: ______
Head Circ (0 - 24 mos)_________________  BMI: (9 mos to 20 yrs)________  Resp: _______

Screenings:
Dental Screen: Observations: ________________________________
Vision Screen: Corrected/Uncorrected (circle one)  Left eye ____/____  Right Eye ____/____
Physical Activity: ________________________________
Hearing Screen: Within normal limits?  YES/NO
Speech: Within Normal Limits?  YES/NO  Nutritional Screen: Adequate/Inadequate
Growth/Developmental Screen: Age Appropriate?  YES/NO

Physical Examinations
Are These Normal?  Normal  Describe Abnormal Findings:
Skin/Hair/Nails  Tuberculin Test
Ears
Eyes
Nose/Mouth/Throat
Teeth/Gums
Head/Neck
Respiratory
Cardiovascular
Abdomen/Gastrointestinal
Endocrine
Genitourinary/Breast (if applicable)
Pelvic Exam (if applicable)
Extremities/Musculoskeletal ROM
Back/Hips
Neurological
Labs Ordered:

Lead Risk?  YES/NO

Assessment Summary & Treatment Plan: Describe on front of form under "TREATMENT"

Immunizations due or administered during the visit:

Referrals:
- ☐ WIC  ☐ Dental  ☐ Vision  ☐ Hearing  ☐ Developmental  ☐ Other (please specify on front of form)

Clinician Printed Name  *Signature on front of Record of Medical Treatment Form