

**Helping Other People's Enrichment, Inc. (HOPE, Inc.)**  
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**(804) 684-2555 / Fax (804) 642-6722**

**REPORT OF PHYSICAL EXAMINATION**

Full Name of child: \_\_\_\_\_ Birth date: \_\_\_\_\_

**PART I**

*(To be completed by agency, if obtainable)*

**Health and Developmental History**

A. Significant events in the child's developmental history include:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

B. Serious illnesses, accidents, operations, nutritional, dental, mental, emotional Problems, or handicapping conditions include:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**PART II**

*(To be completed by Physician)*

**A. Documentation of Immunizations**

Immunizations	Vaccine Doses Administered				
Diphtheria Tetanus Pertussis (DPT)	1. ___/___/___ Mo Day Yr.	2. ___/___/___ Mo Day Yr.	3. ___/___/___ Mo Day Yr.	4. ___/___/___ Mo Day Yr.	5. ___/___/___ Mo Day Yr.
Diphtheria Tetanus (TD)	1. ___/___/___ Mo Day Yr.	2. ___/___/___ Mo Day Yr.	3. ___/___/___ Mo Day Yr.	4. ___/___/___ Mo Day Yr.	5. ___/___/___ Mo Day Yr.
Poliomyelitis (OPV)	1. ___/___/___ Mo Day Yr.	2. ___/___/___ Mo Day Yr.	3. ___/___/___ Mo Day Yr.	4. ___/___/___ Mo Day Yr.	5. ___/___/___ Mo Day Yr.
Measles	___/___/___ Live Virus Vaccine? Yes No Mo Day Yr.			Serological Confirmation of Immunity ___/Month ___/Day ___/Yr.	
Rubella	___/Month ___/Day ___/Yr.			Serological Confirmation of Immunity ___/Month ___/Day ___/Yr.	
Mumps	___/Month ___/Day ___/Yr.				
Measles, Mumps Rubella (MMR)	___/Month ___/Day ___/Yr. ___/Month ___/Day ___/Yr.				

B. Documentation of Medical Examination (*Evaluate each of the following*):

1. Growth and development \_\_\_\_\_  
\_\_\_\_\_

2. Height \_\_\_\_\_ Weight \_\_\_\_\_ B/P \_\_\_\_\_

3. Vision:       W/O Glasses: R20/ \_\_\_\_\_ L20/ \_\_\_\_\_  
                  W Glasses:    R20/ \_\_\_\_\_ L20/ \_\_\_\_\_  
                  Color discrimination: \_\_\_\_\_

4. Hearing:       Right \_\_\_\_\_ Left \_\_\_\_\_

5. Urinalysis: \_\_\_\_\_

6. Hemoglobin: \_\_\_\_\_

7. Nutritional status: \_\_\_\_\_

8. Dental status: \_\_\_\_\_

9. Evidence of freedom from:  
a. communicable disease, *including tuberculosis* \_\_\_\_\_  
b. allergies \_\_\_\_\_  
c. chronic conditions \_\_\_\_\_

10. Other (*specify*) \_\_\_\_\_

11. Normal Evaluation:       Yes \_\_\_\_\_ No \_\_\_\_\_

12. If not, describe abnormal or handicapping conditions:  
a. \_\_\_\_\_  
b. \_\_\_\_\_  
c. \_\_\_\_\_

13. Recommendations:  
a. Permitted/restricted activities:  
   (1) \_\_\_\_\_  
   (2) \_\_\_\_\_  
   (3) \_\_\_\_\_  
   (4) \_\_\_\_\_  
b. Follow-up:  
   (1) \_\_\_\_\_  
   (2) \_\_\_\_\_  
   (3) \_\_\_\_\_  
   (4) \_\_\_\_\_

Date of Medical Examination: \_\_\_\_\_

\_\_\_\_\_  
**Printed Signature of Licensed Physician**

\_\_\_\_\_  
**Signature of Licensed Physician**

Date of Signature: \_\_\_\_\_