



PHYSICAL EXAMINATION FORM

To be completed by a licensed physician, physician's assistant, or nurse practitioner within the last 12 months.

Name _____ Date _____

Birthdate _____ Age _____

Height _____ Weight _____

Blood Pressure _____

Code: (√) Normal (X) Abnormal, please explain:

Skin _____ Chest _____

Eyes _____ Throat _____

Ears _____ Teeth _____

Nose _____ Heart _____

Abdomen _____ Extremities _____

Any diet or activity restrictions? _____

If yes, please explain _____

Regimen of regular medications (including allergy medications):

Any special health requirements and suggestions for treatment while on the farm?

Please complete the immunization chart below, indicating the date of vaccine.

DPT				DT/dt				
OVP				IPV				
HEP				MMR				

Physician authorization for participation in program

The child herein described and examined is in good health and may participate in all farm activities.

Physician's signature _____ Date _____

Physician's Name (please print clearly) _____

Clinic Address _____

Telephone # _____