

WELL CHILD EXAM FORM

Name _____ DOB _____ Sex _____

Mother _____ Father _____

DATE							
Age							
VITAL STATS							
Temp							
Head Circ							
Length							
Weight							
HEAD							
Fontanel							
Other							
Ears							
Eyes							
Nose							
CHEST							
RR							
Extra Sounds							
HEART							
HR							
Rhythm							
other							
Abdomen							
NEURO-MUSCULAR							
Extremities							
Skin							
Other							
Comments							