PARENT-CHILD DEVELOPMENT CORPORATION
P.O. Box 799
West Point, VA 23181

PHYSICAL EXAMINATION RECORD

To Be Completed By Employee:

Name:______________________________ Position:____________________

Address:____

Race: _____ Sex: _____ D.O.B: _________ Can you lift up to 50 lbs? Yes___ No___

Past Medical History (Esp. Back/Lung Problems): ____________________________

Allergies: (Food, Environmental, etc.)_________________________________

Do You Use: Tobacco ____ Alcohol: ____ Marijuana:____ Drugs:_______

Signature:______________________________ Date:____________________

To Be Completed By Physician:

Height: ________ Weight: ________ Temp: ________ Resp: ________

Pulse: __________ Blood Pressure: __________ Heart:________________

Corrective Lenses: Yes __ No _____ Vision O.D. _________ O.S. _________

PPD: Date Administered __________ Date Read: __________ Results: ____________

Patient is free of communicable diseases: Yes ______ No ________

Comment:____

____

Overall health: Excellent Good Fair Poor

Comments: ____

Physician/PA/NP Signature: ______________________________ Date: __________

Printed Name of Medical Authority:____________________________________