

**Mississippi Department of Human Services
 Division of Youth Services
 Oakley Youth Development Center
PHYSICAL EXAMINATION FORM I**

Name: _____ Admission Date: _____ DOB: _____ Allergies: _____ _____	Height: _____ Weight: _____ Date: _____ T: _____ P: _____ R: _____ B/P: _____
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TO BE COMPLETED BY PHYSICIAN

Head:	Eyes:	Fundi:

Hearing:	Ears:	Nose:

Throat/Mouth:	Neck/Thyroid:

Chest/Lung/Heart:

Pulses:

Spine:

Abdomen:

Genitalia:	Lymph nodes:

Extremities/Back:

Neuromuscular:	Skin:

Name: _____ Admission Date: _____ DOB: _____ Allergies: _____ _____	Mississippi Department of Human Services Division of Youth Services <u>HEALTH ASSESSMENT PROBLEM</u> <u>SUMMARY AND PLAN OF CARE II</u>
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Diagnosis/ Problems (Name and Discuss): _____ _____ _____

Medical Treatment/ Plan For Each Problem: _____ _____ _____ _____

Comments: _____ _____ _____ _____ _____

As best can be determined by this Physical Exam, this youth is ok for:
<input type="checkbox"/> Full Activity
<input type="checkbox"/> Limited Activity – Describe:
<input type="checkbox"/> No Physical Activity until further testing or review - Describe:

Physician's Signature _____ **Date** _____