

# child's personal screening and exam schedule

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Review with your child's doctor and discuss at what age these tests are needed.

	<b>DATE TEST COMPLETED</b>							
Height/Weight								
Blood Pressure								
Physical Exam								
Total Skin Exam								
Scoliosis Check								
Breast Exam								
Testicular Check/Genital Exam								
Hearing Exam								
Vision Exam								
Dental Exam								
Hemoglobin								
Cholesterol Screening								
CBC								
Lead Screening								
Urinalysis								
<i>Other Test</i>								
<i>Other Test</i>								
<i>Other Test</i>								