

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

<b>Name:</b> _____ <b>Admission Date:</b> _____ <b>DOB:</b> _____ <b>Allergies:</b> _____ _____	<b>Height:</b> _____ <b>Weight:</b> _____ <b>Date:</b> _____ <b>T:</b> _____ <b>P:</b> _____ <b>R:</b> _____ <b>B/P:</b> _____ <b>OD:</b> _____ <b>OS:</b> _____ <b>OU:</b> _____
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**TO BE COMPLETED BY PHYSICIAN**

<b>Head:</b>	<b>Eyes:</b>	<b>Fundi:</b>

<b>Hearing:</b>	<b>Ears:</b>	<b>Nose:</b>

<b>Throat/Mouth:</b>	<b>Neck/Thyroid:</b>

<b>Chest/Lung/Heart:</b>

<b>Pulses:</b>

<b>Breast/Genitalia:</b>	<b>Tanner Stage:</b>

<b>Abdomen:</b>

<b>Pelvic:</b>	<b>Lymph nodes:</b>

<b>Spine:</b>

<b>Extremities/Back:</b>

<b>Neuromuscular:</b>	<b>Skin:</b>

Name: \_\_\_\_\_

Admission Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Allergies: \_\_\_\_\_  
\_\_\_\_\_

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**HEALTH ASSESSMENT PROBLEM  
SUMMARY AND PLAN OF CARE II**

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:

Full Activity

Limited Activity – Describe:

No Physical Activity until further testing or review - Describe:  
\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_