

KINDERGARTEN/PRESCHOOL PHYSICAL FORM

Last Name _____ First _____ Middle Initial _____ Birthplace _____
Address _____ City _____ Home Phone _____
Parent or Guardian _____ Family Physician _____ Address _____ Gender _____
Medicine Taken Regularly _____ Conditions which could affect school activities _____

PARENTS: Please complete the above area before taking to the doctor's office.

Please check if your child has had the following illness:

1. Allergies No Yes to Medication _____ to Foods _____ Latex _____
2. Asthma No Yes Medication Name _____
3. Chicken Pox No Yes Disease Date _____
4. Diabetes No Yes _____
5. Ear Infections No Yes _____
6. Ear Tubes No Yes Date _____ Still in place? _____ R _____ L _____ Both _____
7. Pneumonia No Yes Date _____ Hospitalized? _____
8. Tonsillitis No Yes _____

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PHYSICAL EXAM

Height (inches) _____ Weight (lbs) _____ Hbg _____ UA _____ Lead _____ General Appearance: Healthy Other _____ Posture: Normal
 Other _____ Nutrition: Good Fair Poor _____
Nose & Throat Normal Other _____ Eyes & Ears Normal Other _____ Vision: Rt ___/___ Lt ___/___ Tonsils & Glands Normal Other _____
Heart & Lungs Normal Other _____ Abdomen Normal Other _____

Pertinent Family History

Operations or Injuries

EXAMINED BY: _____ **Date** _____

DATE _____