

**Preschool & Kindergarten Physical**

Child's Name: \_\_\_\_\_ DOB \_\_\_\_\_ M/F  
 \_\_\_\_\_  
 First Last MM/DD/YYYY

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 \_\_\_\_\_  
 Street City Zip Code Street City Zip Code

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Work Address \_\_\_\_\_  
 \_\_\_\_\_  
 Street City Zip Code Street City Zip Code

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Family Physician \_\_\_\_\_ Phone: \_\_\_\_\_  
 Hospital Preference (for emergencies) \_\_\_\_\_

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Infl. B) RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

**Child Health Assessment**

**This needs to be completed prior to the student entering kindergarten.**

PAST HEALTH HISTORY (DEVELOPMENTAL - ILLNESS - HOSPITALIZATION)

ALLERGIES \_\_\_\_\_  
 CURRENT MEDICATIONS \_\_\_\_\_  
 NUTRITIONAL STATUS \_\_\_\_\_

PHYSICAL EXAMINATION:

HEIGHT _____	WEIGHT _____
HEAD _____	ABDOMEN _____
EENT _____	GU _____
TEETH _____	GYN _____
HEART _____	SKELETAL _____
LUNGS _____	NEUROLOGICAL _____
SCREENING TESTS (DATES DONE AND RESULTS)	
VISION _____	TBC.TEST _____
HEARING _____	SICKLE CELL _____
SPEECH _____	HGB. _____
DDST _____	U.A. _____
OTHER _____	

DIAGNOSIS: \_\_\_\_\_

RECOMMENDATION: \_\_\_\_\_

DO YOU SEE THIS CHILD FOR REGULAR HEALTH SUPERVISION: YES NO

Signature of Licensed Physician or Nurse Approved for Child Health Assessments \_\_\_\_\_ Date ( MM/DD/YYYY) \_\_\_\_\_

\_\_\_\_\_ Phone # \_\_\_\_\_

Print the Name of the Individual Signing Above

Address of Physician or Nurse \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_