

# PRESCHOOL/PRE-K PHYSICAL

## Physical Examination

Date of Examination \_\_\_\_\_

Child's Name \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Skin \_\_\_\_\_ Head and Scalp \_\_\_\_\_ Lymph nodes \_\_\_\_\_

Eyes \_\_\_\_\_ Nose \_\_\_\_\_ Lymph nodes \_\_\_\_\_

Ears \_\_\_\_\_ Left TM \_\_\_\_\_ Right TM \_\_\_\_\_

**Mouth:** Teeth \_\_\_\_\_ Gingiva \_\_\_\_\_ Palata \_\_\_\_\_

Throat \_\_\_\_\_ Chest \_\_\_\_\_ Heart \_\_\_\_\_

B.P. \_\_\_\_\_ Femoral Pulse \_\_\_\_\_ Lungs \_\_\_\_\_ Abdomen \_\_\_\_\_

Genitalia \_\_\_\_\_ Rectum, anus \_\_\_\_\_

Spine and Back \_\_\_\_\_ Extremities \_\_\_\_\_

Neuromuscular \_\_\_\_\_ Gait \_\_\_\_\_

Urinalysis \_\_\_\_\_

**Vision:** Right eye \_\_\_\_\_ Left Eye \_\_\_\_\_ Both \_\_\_\_\_

**Hearing:** Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ Not tested \_\_\_\_\_

Hemoglobin or Hematocrit \_\_\_\_\_

Tuberculin Screening \_\_\_\_\_ Sickle cell screening \_\_\_\_\_

Development testing \_\_\_\_\_ Lead screening \_\_\_\_\_

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

Findings and recommendations:

I have examined \_\_\_\_\_ he/she is \_\_\_\_\_ is not \_\_\_\_\_

Physically and emotionally able to participate in your program.

Comments: \_\_\_\_\_

Immunizations are \_\_\_\_\_ are not \_\_\_\_\_ complete for age.

Immunization schedule:

Date of MMR if needed \_\_\_\_\_

Date of next DPT, Polio or DT booster \_\_\_\_\_

Blood Lead testing date \_\_\_\_\_

Signature of Physician \_\_\_\_\_

Date \_\_\_\_\_

This Physical examination must be filled out by your doctor's office, signed by your doctor and returned with an immunization sheet to us not later than the first day of preschool.

**STATE LAW PROHIBITS ANY EXCEPTIONS**

Don't forget to get your child's immunization record when at the doctor's office for their physical.