PRESCHOOL/PRE-K PHYSICAL

Physical Examination Date of Examination_____
Child's Name_____
Age_____ Height_____ Weight_____
Skin_____Head and Scalp_____Lymph nodes_____
Eyes_____Nose_____Lymp 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.