Physical Exam Form

Please present this form with your kindergarten student to your health care provider prior to a scheduled appointment.

Child's Name:	Phone #:
Parent's Name:	Address:
School Name:	Phone #:

Section 1 – PHYSICAL ASSESSMENT

Did the examination reveal any abnormalities in the following areas?

	Yes	No	Abnormal/Disability Condition(s)
General Appearance	[ ]	[ ]	
Skin	[ ]	[ ]	
Lymph nodes	[ ]	[ ]	
Eyes	[ ]	[ ]	
Nose/Throat	[ ]	[ ]	
Teeth/gums	[ ]	[ ]	
Tongue/Palate	[ ]	[ ]	
Heart	[ ]	[ ]	
Lungs	[ ]	[ ]	
Abdomen	[ ]	[ ]	
Genitalia System	[ ]	[ ]	
Neuro Muscular	[ ]	[ ]	
Skeletal System	[ ]	[ ]	

Medication Prescribed _____

Adequate Nutrition_____

Specific Asthma / Allergies_____

Section 2 – SCREENING

Medical screening results:

	Results	%	Follow-up
Blood Pressure	_____	_____	_____
Height	_____	_____	_____
Weight	_____	_____	_____
BMI	_____	_____	_____
Glucose	_____	_____	_____
Hematocrit	_____	_____	_____
Urine	_____	_____	_____
Lead Level	_____	_____	_____

Audiologist screening results: DATE:

Visual Acuity R [_____] L [_____] Both [_____]
Audiogram R [_____] L [_____] Both [_____]

Audiologist Signature: _____

Last Dental Exam: _____

Section 3 – CHILD HEALTH STATUS (Check all that apply)

1. [Y] [N] Child is receiving routine screening and preventative care (preventative services would include: Well Child Care, Routine Dental Care, - prophy & exam, Immunizations current for age)
2. [Y] [N] Child has acute or chronic condition(s) and is :
   - [ ] (A) receiving adequate ongoing care
   - [ ] (B) needs to establish services
   - [ ] (C) needs to update or re-establish services
3. [Y] [N] Child's status cannot be determined from available information (health history unavailable or inadequate.)
4. [Y] [N] Child needs to establish preventative services: [ ] Well Child Care, [ ] Immunization Update, [ ] Routine Dental Care [ ] Mental Health, [ ] Other:_____

General impression of child's current health condition: _____

Follow-up _____

Section 4 – SAFETY

Knows own information _____

Bicycle helmet _____ Street safety _____

Child's Medical Statement

This is to certify that I have examined the above-named child on (date) _____ and have found that this child, based upon his/her medical history and physical condition at the time of this examination, is free from apparent communicable diseases and is in suitable condition for enrollment in an early childhood program.

X_____
Health Professional's Signature

Child's Birth Date _____/_____/_____
MM DD YY

_____
Street Address

_____
City State Zip Phone