

# KINDERGARTEN/PRESCHOOL PHYSICAL FORM

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ 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:

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 \_\_\_\_\_
9. Blood Lead Test  No  Yes Date \_\_\_\_\_

## 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 \_\_\_\_\_ Tonsils & Glands  Normal  Other \_\_\_\_\_  
Heart & Lungs  Normal  Other \_\_\_\_\_ Abdomen  Normal  
 Other \_\_\_\_\_

### Pertinent Family History

Operations or Injuries \_\_\_\_\_

EXAMINED BY: \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

NOTE: IMMUNIZATIONS CERTIFICATE, DENTAL CERTIFICATE AND KINDERGARTEN PHYSICAL ARE DUE WITH REGISTRATION FORMS! Rev. 1/09