Preschool/Pre-K Physical

Physical Examination

Date of Examination: _____

Child's Name: _____

Age _____ Height _____ Weight _____
Skin _____ Head & Scalp _____ Lymp nodes _____
Eyes _____ Nose _____
Ears _____ Left TM _____ Right TM _____

Mouth: Teeth _____ Gingiva _____ Palata _____

Throat _____ Chest _____ Heart _____
B.P. _____ Femoral Pulse _____ Abdomen _____
Genitalia _____ Rectum, Anus _____
Spine & 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 & 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.

Immunizations schedule:

Date of MMR if needed _____
Date of next DPT, Polio or DT booster _____
Blood lead testing date _____

_____

Signature of Primary Care Provider/Physician *Date*

This physical examination form must be filled out and signed by your Primary Care Provider/Physician and returned with an immunization sheet. These need to be in no later than the first day of school.

State Law Prohibits Any Exceptions