



## PRESCHOOL/KINDERGARTEN SCHOOL ENTRANCE PHYSICAL EXAMINATION

(to be completed and signed by a physician)

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
(Month/Day/Year)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

General appearance, nutritional state: \_\_\_\_\_

	Normal	Abnormal		Normal	Abnormal	
Posture			Neck			Vision R 20/_____ L 20/_____
Skin			Heart			
Eyes			Lungs			
Ears			Abdomen			
Nose			Genitalia			Hearing Test Type: _____ R _____ L _____
Throat (Tonsils)			Hernia			
Mouth (Teeth)			Nervous System			
Musculoskeletal			Other (Specify)			

Remarks and recommendations concerning any abnormal findings:

\_\_\_\_\_

What medication, if any, is the child taking?

\_\_\_\_\_

Reason for medication: \_\_\_\_\_

Was child referred to a specialist for any reason (specify)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Attach a copy of the child's current immunization record.**

Immunizations (circle one) Complete or In Process

### Special Tests (at discretion of physician)

Urinalysis: \_\_\_\_\_ Hemoglobin: \_\_\_\_\_ Other: \_\_\_\_\_

Other (specify type and dates): \_\_\_\_\_

Tuberculin Test: \_\_\_\_\_ Type: \_\_\_\_\_ Results: \_\_\_\_\_ Positive \_\_\_\_\_ Negative \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Physician (please print): \_\_\_\_\_ Phone Number: \_\_\_\_\_