TRANSITIONAL KINDERGARTEN/KINDERGARTEN/PRESCHOOL PHYSICAL FORM

Last Name_____ First_____ Middle Initial_____ Birthdate_____

Address_____ City_____ Home Phone _____

Parent or Guardian_____ Family Physician_____ Address_____

Gender_____ Medicine Taken Regularly_____

Conditions which could affect school activities_____

PARENTS: Please complete the above area before taking to the doctor's office.

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Please check if your child has had the following illness:

1. Allergies ❒ No ❒ Yes to Medication_____ to Foods_____ to 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 _____

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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 & Ear ❒ Normal ❒Other_____ Tonsils & Glands ❒ Normal ❒Other_____

Heart & Lungs ❒ Normal ❒Other_____ Abdomen ❒ Normal ❒Other_____

Pertinent Family History_____

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Operations or injuries_____

EXAMINED BY:_____ **DATE**_____

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