KINDERGARTEN PHYSICAL FORM

Last Name_______________________________ First_____________________________Middle Initial __________ Birthplace______________

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___________________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 & Ears ❒ 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**______________________________

DATE____________________

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