KINDERGARTEN PHYSICAL EXAM

Student's Name____
Last First Middle Initial

Parent/Guardian's Name____

Address____

Home Phone Number______________________________Work Phone Number__________________

Family Physician_____________________________________Phone Number____________________

Date of Birth____________________________Place of Birth___________________________________

Significant past illnesses, injuries and surgeries:___________________________________
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Daily or regular medications:___________________
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IMMUNIZATIONS
1. DPT
2. Polio
3. Measles
4. Rubella
5. Mumps
6. Hepatitis B
7. Varicella
Waiver Signed

Height____________________
Weight____________________
Blood Pressure______________
Hgb or Hct_________________
Urinalysis__________________

	Normal	Abnormal	Comments
1. Head			
2. Ears			
3. Eyes (contacts/glasses)			
4. Nose			
5. Throat			
6. Teeth			
7. Neck			
8. Chest			
9. Lungs			
10. Heart			
11. Abdomen (hernias)			
12. Genitalia			
13. Back(scoliosis)			
14. Extremities & Feet			

Student should be excluded from the following activities:_____________________________________
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Date of Examination____________________Physician Signature______________________________________