Kindergarten Physical Exam
(Top half to be completed by parent before physical exam)

Name_____ Male___Female___ Date of Birth_____
Address_____ Phone_____
Parent/Guardian_____
_
Primary Physician_____ Dentist_____
Did your child have an Early Childhood Screening? Yes/No If so, where?_____

Significant Past Medical History

Allergies(Specify below)		ADHD/Anxiety/Mental Health	
Asthma		Developmental Delay	
Chicken Pox		Seizure History	
Congenital Defect(Specify below)		Vision	
Diabetes		Hearing	
Heart Condition		Surgeries(specify below)	
Neurologic Condition(Specify below)		Medications	
Orthopedics (specify below)		Other(Specify below)	

Specify Here:_____
_____

Health Exam
(To be completed by Physician/Health Care Provider)

Physician's Name_____
Height_____Weight_____Pulse_____BP_____Urinalysis_____HGB_____Other_____
Eyes_____ Orthopedic_____
Ears_____ Skin_____
Nose_____ Allergies_____
Throat_____ Nutrition_____
Lungs_____
Scoliosis_____
Heart_____ Hernia_____
Nervous System_____ Other_____

Does student require medication daily?_____Name of Medication_____
Dose_____ Frequency_____ Diagnosis_____
History of Concerns: _____Speech _____Hearing _____Social/Emotional
List conditions that may limit participation in:
Classroom Activity_____
Physical Education/Competitive Sports_____

Approved for: Full Activity_____ Limited Activity_____
Physician Signature_____ Date_____