



Kindergarten Physical Exam Form

Charles City Community Schools

Child's Name _____ Sex ___M ___F Date of Birth _____

Height _____ Weight _____ B/P _____ Vision R _____ Vision L _____

Did the examination of the following reveal any abnormalities in the following areas?

	WNL	Atypical	Remarks re: Atypical Findings
General Appearance	()	()	_____
Speech	()	()	_____
Eyes	()	()	_____
Ears	()	()	_____
Nose/Throat	()	()	_____
Head/Neck	()	()	_____
Heart	()	()	_____
Lungs	()	()	_____
Abdomen	()	()	_____
Genitourinary	()	()	_____
Neuromuscular	()	()	_____
Other Abnormalities	()	()	_____

Lead Testing YES _____ NO _____

Has this child had any serious illness, injury, or hospitalization that will require special consideration by school?

Does this child have any allergies? (food, bee stings, drugs, inhalants, other) YES _____ NO _____

Please detail reaction and treatment.

Is this child on a daily prescription medication? YES _____ NO _____

<u>Medication</u>	<u>Dose</u>	<u>Time</u>	<u>Condition Requiring Medication</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Immunization record attached YES _____ NO _____

Does this child have any health condition which may require interventions or modification of school programs?

Has this child any physical or emotional conditions which may require special consideration by the school?

Physician's Signature _____ Date _____