Kindergarten Physical Examination

TO BE COMPLETED BY PHYSICIAN

Child's Name________________________ School_________________________

Age_____ Ht________ Wt_________

Skin___________________________ Head and Scalp______________________

Eyes________________ Nose_________________ Lymph Nodes_____________

Ears________________ Throat________________ Chest____________________

Heart_______________ BP___________________ Lungs___________________

Abdomen______________ Genitalia_______________ Rectum, anus____________

Spine & Back______________________________ Extremities__________________

Neuromuscular_____________________________ Gait________________________

Vision: (R) ____________ (L)_______________ Both_______________________

Hearing: Normal _____________ Abnormal ___________ Not Tested____________

Hemoglobin or Hematocrit______________________ Tuberculin Screening________

Development Testing___________________________ Other_____________________

Summary of findings and recommendations: I have examined___________________

And in my opinion, He /she is ____ (is not____) physically and emotional able to

Participate in your preschool/kindergarten program.

Additional comments:____
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Immunizations are ____ (are not ____) complete for age.

Signature of Physician_____________________________

Date ____________________________________