

# Preschool

## PHYSICAL EXAM FORM \_\_\_\_\_

**INFORMATION TO BE FILLED OUT BY PHYSICIAN / HEALTH CARE PROVIDER:**

Name: \_\_\_\_\_

Age: Year \_\_\_\_\_ Months \_\_\_\_\_

Hemoglobin/Hematocrit:	Lead:	Height Inches	Blood Pressure	
Urinalysis Results: (If indicated):	Vision: L R	Developmental Screening:	Hearing:	
Does the examination reveal any abnormality?	Normal	Abnormal	Not Examined	Describe fully any abnormal findings
General Appearance, Posture, Gait				
Speech / Language Development				
Behavior during examination				
Skin				
Eyes: Extraocular Movements				
Ears: Canal, Tympanic Membrane				
Nose, Mouth, Pharynx, Tonsils				
Teeth				
Heart				
Lungs				
Abdomen (include hernias)				
Genitalia				
Extremities, Feet				
Neurological				
Other				

Summary of findings and recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Physician or Health Care Provider

Date

Health Agency Where Examination Completed \_\_\_\_\_

1. Health Statement- To be completed by **Parent:**

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Significant Illnesses and surgeries child has had (give age at time)**

\_\_\_\_\_

Any special health-related needs of child (allergies, medications, injuries, etc.)

\_\_\_\_\_

2. Physical Assessment – To be completed by **physician / health care provider:**

1. Is there any defect of vision, hearing or speech of which the child care program should be aware, or could compensate by appropriate action?

\_\_\_\_\_  
\_\_\_\_\_

2. Is this child subject to any conditions which limit classroom activities or physical education?

\_\_\_\_\_  
\_\_\_\_\_

3. Is this child subject to any condition which may result in an emergency situation?

\_\_\_\_\_  
\_\_\_\_\_

4. Is this child subject to any mental or physical condition for which he/she should remain under periodic medical observation?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Are immunizations up to date? \_\_\_\_\_ Yes \_\_\_\_\_ No If no what is needed?

\_\_\_\_\_  
\_\_\_\_\_

6. Other significant findings: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

She/he Is/Is not (circle one) physically and emotionally able to participate in the program.

Recommendations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date of Examination \_\_\_\_\_ Physician

Signature \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_