KINDERGARTEN/PRESCHOOL PHYSICAL AND DENTAL FORM

Last Name_____ First Name_____ Middle Initial_____ Birthdate_____

Address_____ City_____ Home Phone_____

Parent or Guardian_____ Family Physician_____ Address_____

Gender_____ Medicine Taken Regularly_____

Conditions that could affect school activities_____

Parents: Please complete the above area before taking to the doctor's office.

Please check if your child has had the following illness:

1. Allergies ☐ No ☐ Yes to Medication_____ to Foods_____ to Latex_____
2. Asthma ☐ No ☐ Yes Medication Name_____
3. Chicken Pox ☐ No ☐ Yes Disease Date_____
4. Diabetes ☐ No ☐ Yes _____
5. Ear Infections ☐ No ☐ Yes _____
6. Ear Tubes ☐ No ☐ Yes Date_____ Still in place?_____ R_____ L_____ Both_____
7. Pneumonia ☐ No ☐ Yes Date_____ Hospitalized?_____
8. Tonsilitis ☐ No ☐ Yes _____

PHYSICAL EXAM

Height (inches)_____ Weight (lbs)_____ Hbg_____ UA_____

B/P_____ P_____ R_____ T_____ Visual Acuity_____ Both_____ R_____ L_____

General Appearance ☐ Healthy ☐ Other_____ Posture ☐ Normal ☐ Other_____

Nutrition ☐ Good ☐ Fair ☐ Poor_____ Nose & Throat ☐ Normal ☐ Other_____

Eyes and Ears ☐ Normal ☐ Other_____ Tonsils & Glands ☐ Normal ☐ Other_____

Heart and Lungs ☐ Normal ☐ Other_____ Abdomen ☐ Normal ☐ Other_____

Pertinent Family History: _____

_____

Operations or Injuries: _____

EXAMINED BY:_____ **DATE:**_____

DENTAL EXAM

Condition of Teeth: _____

Condition of Gums_____

Additional Comments_____

EXAMINED BY:_____ **DATE:**_____

NOTE: IMMUNIZATION CERTIFICATE AND KINDERGARTEN PHYSICAL ARE DUE WITH REGISTRATION FORMS!