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	( )	( )	_____

Urinalysis _____ Hg/Ht _____ Lead Testing _____

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 ( )

Medication	Dose	Time	Condition requiring medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Immunizations Completed ____ YES ____ NO Immunizations Needed _____

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

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

Physician's Signature _____ Date _____

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