Kindergarten Physical Exam Form
Charles City Community School District

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 hospitaliaztion 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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_____