

Wakonda Preschool
Physical Examination Form

Child's Name _____
Birthdate: _____ Sex: _____ SSN: _____
Address: _____
City: _____ State: _____ Zip: _____

Health History

To be completed by parent of guardian:

Chicken Pox	YES	NO	Vision Problems	YES	NO
TB/TB Contact	YES	NO	Serious Injuries	YES	NO
Birth Defects	YES	NO	Bone Joint Problems	YES	NO
Blood Disorder	YES	NO	Surgery	YES	NO
Hemophilia _____	sickle cell _____		Hospitalization	YES	NO
Diabetes	YES	NO	Asthma	YES	NO
Seizures	YES	NO	Medications _____		
Heart Problems	YES	NO	_____		
Ear/Hearing Problems	YES	NO	_____		
Chronic Ear Infections	YES	NO	Explanation to any of the above _____		
Speech Problems	YES	NO	_____		

Parent's or Guardian's Signature _____ Date _____

To be completed by Physician:

Age _____ Height _____ Weight _____

Normal	Normal
<input type="checkbox"/> Skin _____	Head & Scalp _____
<input type="checkbox"/> Eyes _____	Nose _____
<input type="checkbox"/> Lymph Nodes _____	Ears _____
<input type="checkbox"/> Mouth _____	Teeth _____
<input type="checkbox"/> Gingiva _____	Palette _____
<input type="checkbox"/> Throat _____	Chest _____
<input type="checkbox"/> Heart _____	Lungs _____
<input type="checkbox"/> Genitalia _____	Abdomen _____
<input type="checkbox"/> Spine & Back _____	Rectum, Anus _____
<input type="checkbox"/> Neuromuscular _____	Extremities _____
<input type="checkbox"/> Urinalysis _____	Gait _____

Vision: (R) eye _____ (L) eye _____ Both _____
Hearing: Normal _____ Abnormal _____ Not tested _____

If needed: Hemoglobin or Hematocrit _____
Tuberculin Screening _____
Sickel cell Screening _____
Developmental testing _____
Lead Screening _____

Allergies: _____

Summary of findings: I have examined _____
He/She is ___ is not ___ physically and emotionally able to participate in your program.

Additional
Comments: _____

Date of Physical Examination _____

Signature of Physician or Designee

Date