KINDERGARTEN PHYSICAL EXAMINATION FORM
GREEN HILLS SCHOOL

Required Physical Examination of Kindergarten Pupils.....Board Policy
The examination must include the items listed below be completed and submitted to the
School Nurse by June 30th or ASAP following 5th Birthday.

NAME_____ BIRTHDATE_____TELEPHONE_____

Height_____ Weight_____ Blood Pressure_____Pulse_____

General Appearance_____

Ears(Otoscopic)_____	Hernia_____	Eyes(fundascopic_____
Genito-Urinary_____	Lymph Glands_____	Orthopedic Structura_____
Thyroid_____	Scoliosis_____	Nose_____
Posture_____	Throat_____	Feel_____
Teeth-Mouth_____	Skin_____	Heart_____
Nutrition_____	Lung_____	Nervous System_____
Abdomen_____	Speech_____	

History of illness, injury or

Other_____

Surgery_____

Has child been tested for blood lead levels? Date: _____ Results: _____

Is this child receiving any medication or therapy? If so, please indicate type, dose, reason and duration:

_____

_____

_____

Are there any educational constraints or adjustments in the child's program or physical activities? Please indicate:

_____

_____

Does the child have Emotional/Mental/Behavior Problem? (if yes, please explain)

_____

Does the child have any Problems with Health Habits? (if yes, please explain)

_____

Immunization History (please enter complete date) Month - Day - Year

DPT: _____
or DtaP: _____
_____
_____
_____

OPV: _____
or IPV: _____
_____
_____

MMR: _____
_____
_____
_____

HIB: _____
_____
_____

HEPB: _____
_____
_____

Varicella Zoster: _____

VISUAL

Visual Acuity O.S. _____ O.D. _____ Eye Balance _____

Color Discrimination (please circle) PASS FAIL

Wears Glasses (please circle) YES NO

Observations (circle all that apply)

Crusty Lids	Squinting	Reddened Sclera/Conjunctiva
Watery Eyes	Head Tilt	Strabismus

AUDITORY

	PASS	*FAIL*	*QUESTIONABLE*
Left Ear	_____	_____	_____
Right Ear	_____	_____	_____

	NO	YES
History of Ear Infection	_____	_____
History of Hearing Problem	_____	_____
Myringotomy with tubes	_____	_____

Recheck: _____ Date:_____

This child is physically able to compete in any supervised gym activities: ___Yes ___No

_____ _____
SIGNATURE OF PHYSICIAN *DATE*

_____ _____
PRINT NAME OF PHYSICIAN *PHONE NUMBER*