



ST. MARY PRESCHOOL PROGRAM

PHYSICAL EXAMINATION FORM

*State Law Requires That This Form Be Filled Out Every Year

Child's Name _____ D.O.B. ____/____/____ Source of Payment _____

SECTION 1 – PHYSICAL ASSESSMENT

Did the examination reveal any abnormalities
In the following areas?

General Appearance	YES () NO ()
Skin	YES () NO ()
Lymph Nodes	YES () NO ()
Eyes	YES () NO ()
Ears	YES () NO ()
Nose, Throat	YES () NO ()
Teeth, Gums, Tongue, Palate	YES () NO ()
Heart	YES () NO ()
Lungs	YES () NO ()
Abdomen	YES () NO ()
Genitalia	YES () NO ()
Skeletal System	YES () NO ()
Neuro Muscular	YES () NO ()
Allergies	YES () NO ()
Other	YES () NO ()

SECTION 2- SCREENINGS

*Visual Acuity _____	
*Hematocrit or Hgb _____	*Lead _____
*Height _____	*Weight _____
*Speech _____	*Hearing _____
Urinalysis _____	Blood Pressure _____
Sickle Cell Anemia _____	
Abnormal Handicapping Condition: _____	
Medications: _____	
Dosage _____	Purpose _____

*Required Screenings

SECTION 3 – IMMUNIZATION – Please review documentation provided by parent/guardian and complete this record

Immunization	Date	Date	Date	Date	Date	Date	Date
DPT							
OT							
IPV							
MMR							
HIBS							
Hepatitis B							
Varicella							
TB Test							

MEDICAL HISTORY

___ Asthma	___ Cystic Fibrosis	___ Ear Infection, recurrent	___ Meningitis	___ Tuberculosis
___ Blind	___ Deaf	___ Eczema	___ Seizure Disorder	___ Chicken Pox
___ Diabetes	___ Heart Disease	___ Sickle Cell Anemia	___ Other	

PLEASE IDENTIFY ANY SIGNIFICANT CONCERNS:

Neurologic _____ Orthopedic _____ Seizures (Types & Frequency) _____

Dietary _____ Allergies _____ Other _____

RESTRICTIONS _____ RELEVANT FINDINGS _____

This is to certify that I have examined _____ on ____/____/____ and have found that this child:

Child's Name

- Has had the immunization required by Section 3313.671 of the revised code for admission to school or has had the immunizations required by the State Department of Health for Infants and Toddlers or is to be exempted from these requirements for medical reasons.
- And based upon his/her medical history and physical condition at the time of this examination, is free from apparent communicable disease and is in suitable condition for enrollment in a child day care and/or preschool facility.

Physician's Signature _____ Telephone No. _____

Street Address _____ City, State, Zip _____