Pre-Admission Medical Examination Record for Pre-School & Kindergarten

Date of Physical _____ Male ☐ Female ☐

Child's Name _____ Birth Date _____

Parent's Name _____ Address _____

Family Doctor _____ Address _____

Doctor's Phone Number _____

Any daily medications? Yes No If yes, please list: _____

_____

Allergies: _____

Any conditions which could affect school work? _____

_____

HEALTH HISTORY

Please circle one

Yes	No	ADD/ADHD	Yes	No	Kidney/Bladder infections
Yes	No	Asthma	Yes	No	Rheumatic fever
Yes	No	Bowel/Bladder problems	Yes	No	Seizures
Yes	No	Depression/anxiety	Yes	No	Strep info.
Yes	No	Diabetes	Yes	No	Tuberculosis
Yes	No	Ear infection	Yes	No	Vision problems
Yes	No	Eating problems/dietary considerations	Yes	No	Whooping Cough
Yes	No	Headaches	Yes	No	Chronic or recurrent illness or injury?
Yes	No	Hearing problems	Yes	No	Hospitalizations
Yes	No	Heart problems	Yes	No	Eyeglasses
Yes	No	Immunizations current?			

If yes, please explain, _____

_____

_____

List Operations and Injuries _____

_____

_____

Physical Examination Completed By Physician

	NORMAL	ABNORMAL FINDINGS
Abdomen		
Blood Count		
Blood Pressure		
Ears		
Eyes		
Glands		
Hearing		
Heart		
Height Weight		
Lead Screening-- if previously screened, send a copy of the results		
Lungs		
Musculoskeletal		
Neck		
Neuro-Musc. System		
Nose		
Orthopedic		
Skin		
Throat/ Mouth/Teeth		
Urinalysis		
Vision		
OTHER		

Comments: _____

_____

_____

Signature of Physician _____ Date _____