El Capitan Kindergarten Physical Exam Form

Please present this form with your kindergarten student to your health care provider prior to a scheduled appointment

Child's Name:	Phone #:
Parent's Name:	Address:
School Name:	Phone#:

Section 1 – PHYSICAL ASSESSMENT **SECTION 2 -- SCREENING**

Did the examination reveal any abnormalities:

	Yes	No
General Appearance	[ ]	[ ]
Skin	[ ]	[ ]
Lymph nodes	[ ]	[ ]
Eyes	[ ]	[ ]
Nose/Throat	[ ]	[ ]
Teeth/Gums	[ ]	[ ]
Tongue/Palate	[ ]	[ ]
Heart	[ ]	[ ]
Lungs	[ ]	[ ]
Abdomen	[ ]	[ ]
Genitalia System	[ ]	[ ]
Skeletal System	[ ]	[ ]
Neuro Muscular	[ ]	[ ]

Medical screening results: Follow up:

Blood Pressure_____ _____
Height _____ _____
Weight _____ _____
Hemoglobin _____ _____
Hematocrit _____ _____
Urine _____ _____
Lead Level _____ _____

Audiologist screening results: DATE:_____
Visual Acuity R[____] L[_____] Both [____]
Audiogram R[____] L[_____] Both [____]
Speech _____

Chronic Conditions:_____
_____

Adequate Nutrition_____
Medication Prescribed_____

Section 3 – CHILD HEALTH STATUS (Check all that apply)

1. [Y] [N] Child is receiving routine screening and preventative care (preventative services include: Well Child Care, Routine Dental Care, -prophy & exam, Immunizations current for age)

2. [Y] [N] Child has acute or chronic condition(s) and is:
[ ] (A) receiving adequate ongoing care
[ ] (B) needs to establish services
[ ] (C) needs to update or re-establish services

3.[Y] [N] Child's status cannot be determined from available information (health history unavailable).

4.[Y] [N] Child needs to establish preventative services: [ ] Well Child Care, [ ] Immunization Update, [ ] Routine Dental Care, [ ] Mental Health, [ ]Other:_____

General Impression of child's current health condition:_____

Follow-up_____

Section 4 -- SAFETY

Bicycle helmet_____. Street safety_____

Child's Medical Statement

This is to certify that I have examined the above named child on (date)_____and have found that this child, based upon his/her medical history and physical condition at the time of this examination, is free from apparent communicable diseases and is in suitable condition for enrollment in any early childhood program.

X_____Phone_____Child's Birth Date____/____/____
Health Professional's Signature

_____
Street Address City State Zip