

**Clayton Ridge Community School District**  
**Physical Examination Form for Pre-School and Kindergarten**

Date of Physical \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Parent's Name \_\_\_\_\_ Phone \_\_\_\_\_  
Parent's Address \_\_\_\_\_  
Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_  
Doctor's Address \_\_\_\_\_  
Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_  
Dentist's Address \_\_\_\_\_

List all prescription and over the counter medications your child takes regularly and time taken.

\_\_\_\_\_

List any allergies \_\_\_\_\_

Type of reaction \_\_\_\_\_

List any dietary restrictions \_\_\_\_\_

List any conditions that could affect school work \_\_\_\_\_

**Child's Health History (Circle Yes or No)**

|     |    |                          |     |    |                           |
|-----|----|--------------------------|-----|----|---------------------------|
| Yes | No | ADD/ADHD                 | Yes | No | Hearing Aid               |
| Yes | No | Asthma                   | Yes | No | Heart problems            |
| Yes | No | Bowel/Bladder problems   | Yes | No | Immunizations current     |
| Yes | No | Chicken Pox              | Yes | No | Kidney/Bladder infections |
| Yes | No | Depression / Anxiety     | Yes | No | Rheumatic fever           |
| Yes | No | Diabetes                 | Yes | No | Seizures                  |
| Yes | No | Ear infections           | Yes | No | Strep                     |
| Yes | No | Eating problems          | Yes | No | Tuberculosis              |
| Yes | No | Headaches                | Yes | No | Vision problems           |
| Yes | No | Head injury / Concussion | Yes | No | Hospitalizations          |
| Yes | No | Hearing problems         | Yes | No | Eyeglasses                |

If yes to any of the above, please explain: \_\_\_\_\_

\_\_\_\_\_

Has your child been seen by a dentist? Yes No If yes, when: \_\_\_\_\_

List Operations and Injuries \_\_\_\_\_

\_\_\_\_\_

### To Be Completed By Physician

|  | Normal | Abnormal Findings |
|--|--------|-------------------|
| Abdomen  |        |                   |
| Blood Count  |        |                   |
| Blood Pressure   |        |                   |
| Developmental  |        |                   |
| Ears   |        |                   |
| Eyes   |        |                   |
| Genitals   |        |                   |
| Glands   |        |                   |
| Hearing  |        |                   |
| Heart  |        |                   |
| Height / Weight  |        |                   |
| Lungs  |        |                   |
| Musculoskeletal  |        |                   |
| Neck   |        |                   |
| Neurological   |        |                   |
| Nose   |        |                   |
| Nutrition  |        |                   |
| Orthopedic   |        |                   |
| Posture  |        |                   |
| Skin   |        |                   |
| Throat / Mouth   |        |                   |
| Urinalysis   |        |                   |
| Vision   |        |                   |
| Lead Screening (Required)<br>If previously screened, send a copy |        |                   |

Comments: \_\_\_\_\_

This child is physically qualified to take part in the regular school program    \_\_\_ yes \_\_\_ no

Up-to-date certificate of immunizations attached (**Required**)    \_\_\_ yes \_\_\_ no

**Signature of Physician** \_\_\_\_\_ **Date** \_\_\_\_\_

