AHSTW CSD

(PLEASE PRINT) **PRESCHOOL/TK/KINDERGARTEN PHYSICAL FORM**

Last Name:_____First Name: _____ Middle Initial: _____Birthdate: _____

Address: _____City:_____ Phone: _____

Parent/Guardian: _____

Family Physician: _____ Medical Clinic: _____ Clinic Phone: _____

Gender: _____Medication taken regularly:_____

Please circle Yes or No if your child has had the following conditions:

1. Allergies **Yes / No** To Medication/Food/Latex (If EPI pen, submit action plan from MD):_____
2. Asthma **Yes / No** Medications (please submit action plan from MD): _____
3. Diabetes **Yes / No** Medications (please submit action plan from MD): _____
4. Eczema **Yes / No** Treatment: _____
5. Ear infections/Tubes **Yes / No** Date/tubes in place? R or L or both: _____
7. Head Injury **Yes / No** Date/Ongoing precautions: _____
8. Seizures **Yes / No** Medications/Triggers:(please submit action plan from MD): _____
9. Development disorder **Yes / No** _____
10: Other chronic conditions: _____

Parent Signature: _____ Condition Affecting Such Activities: _____

*****Parents: Please complete the above area before taking to the doctor's office*****

Completed by Physician:

Height (inches):_____Weight(lbs):_____B/P_____P_____Lead Level: _____ Date: _____ (Does not need to be current)

General Appearance: _____Healthy _____Other

Posture:_____

Nutrition: _____Good ____Fair _____Poor

Nose /Throat: _____Normal _____Other (see below)

Eyes and Ears: _____Normal _____Other (see below)

Tonsils / Glands: _____Normal _____Other (see below)

Heart and Lungs: _____Normal ____Other (see below)

Abdomen: _____Normal _____Other (see below)

Vision: R eye_____L eye_____

Dentition: _____No problem _____Needs care ____Needs urgent care

Pertinent Family History: _____

Chronic Diseases:_____

Surgeries or Injuries:_____

Other (from above):_____

Examined by: _____ Printed Name:_____ Date:_____