KINDERGARTEN HEALTH PHYSICAL

Name_____D.O.B_____
Parent's Name_____

	(Month/day/year)					
Dtap/DPT						
DT						
Polio						
MMR						
Hepatitis B						
Varicella						
HIB						
Prevnar						
Other						
Chickenpox Disease						

Health Concerns:

Allergies
Seizures
Asthma
Diabetes
Medications

Height_____Weight_____BP_____

Eye	Hearing
Color:	Right ear: 1000 pass/fail @ db
Vision:	2000 pass/fail @ db
Right eye 20/	4000 pass/fail @ db
Left eye 20/	
Muscle Balance:	Left ear: 1000 pass/fail @ db
Near: pass/fail Distance: pass/fail	2000 pass/fail @ db
Stereopsis: pass/fail	4000 pass/fail @ db

Scalp/Hair	Lice/nits yes/no
Skin	
Nose	
Mouth	
Teeth	
Tonsils	
Adenoids	
Nodes	
Lungs	
Heart	
Abdomen	
Genitalia	
Skeletal	
Posture	
Urine	
Neurological	
Behavior	
Recommendation:	

Physician's Name _____
Physician Signature_____Date_____