Warrensville Heights City School District

KINDERGARTEN PHYSICAL

(To be completed by Physician)

Child's Name: ______________________ **D.O.B:**__________ **Male:**____ **Female:**____

Address: ______________________ Apt. #__________ City: ________________ Zip:____________

Immunizations

(Include Month, Day, and Year for each)

DPT	1)	2)	3)	4)	5)
Polio	1)	2)	3)	4)	5)
HIB	1)	2)	3)	4)	
Hepatitis B	1)	2)	3)		
Tuberculin Test		Results______	Varivax Vaccine		
MMR	1)		Chicken Pox Disease		
			Yes No Date		
MMR Booster	2)				

Examination

	Comments/Concerns		Comments/Concerns
General Appearance		**Posture**	
Height		Skin	
Weight		Musculoskeletal	
Blood Pressure		Heart	
Eyes	R20/ L20/	Lungs	
Ears	R L	Abdomen	
Nose		Genitalia	
Tonsils		Hernia	
Mouth (teeth)		Nervous System	
Neck		Urinalysis	
Nutritional Status		Allergies	

Physician's Name: ____________________ Physician's Signature: ______________________

(Please print)

Address: ______________________ Date: ____________________ Phone Number:______________

Has your child had the Chicken Pox Disease? Yes ____No____ If Yes, Age: ____Year:________.
Parent/Guardian: Date: