PRESCHOOL @The Ridge

# PHYSICAL EXAMINATION

**Child's Full Name** _____ **Date of Exam** _____

**Age** _____ **Height** _____ **Weight** _____ **BP** _____ **P** _____

Vision: Eye Correction required ☐ Yes ☐ No ☐ Glasses ☐ Contact Lens

Hearing: ☐ Normal ☐ Abnormal ☐ Not Tested

| | | |
|---|---|---|
| EENT _____ | Heart _____ | Genitalia _____ |
| Teeth _____ | Abd _____ | Rectum, Anus _____ |
| Neck _____ | Hernia _____ | Neuromuscular _____ |
| Chest _____ | Extremities/Skin _____ | Urinalysis _____ |
| Lungs _____ | Posture/Spine _____ | |

*If needed:*

| | |
|---|---|
| Hemoglobin or Hematocrit _____ | Tuberculin screening _____ |
| Sickle Cell screening _____ | Development testing _____ |
| Lead screening _____ | Other _____ |

**The child is under the care of a physician for the following medical condition(s):**

_____

Known allergies: _____

Additional health information: _____

_____

The child is _____ is not ____ physically and/or emotionally able to participate in your program.

_____
Signature of Physician or Designee

_____
Date

PARENT: Please complete the following:

Diseases the child has had _____

_____

Any special health needs _____

_____