South Gibson School Corporation

KINDERGARTEN PHYSICAL EXAMINATION FORM

Name _____ Date _____

Address _____ Telephone No. _____

City, State, Zip _____

Date of Birth _____ Sex _____ Grade _____

1. Height (in inches) _____ Weight _____
2. Eye Inspection: Without Glasses: R.E. Vision 20/ _____ L.E. Vision 20/ _____
   With Glasses: R.E. Vision 20/ _____ L.E. Vision 20/ _____
3. Ears Right: Discharge _____ Hearing: Normal _____ Dull _____
   Left: Discharge _____ Hearing: Normal _____ Dull _____
4. Nose _____ 5. Throat _____
6. Lymph Nodes _____
7. Thyroid _____ Other Glands _____
8. Heart _____ Blood Pressure _____
9. Lungs _____
10. Abdomen _____ 11. Hernia _____
12. Orthopedic Impairments _____
13. Posture _____
14. Nutrition _____ 15. Skin _____
16. Nervous System _____
17. Ano-rectal _____ 18. External Genitals _____
19. History of severe illnesses, operations, or accidents _____
    _____
20. Diagnostic Tests: Urinalysis _____Tuberculosis _____
21. General Condition _____
22. Immunizations: (GIVE THE DATE OF EACH INJECTION GIVEN)
    DPT (Diptheria – Whooping Cough – Tetanus)
    Infant series: 1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____
    DT (Diptheria – Tetanus) 1st _____ 2nd _____ Booster _____
    Polio (oral) 1st _____ 2nd _____ 3rd _____ 4th _____
    MMR 1st _____ 2nd _____
    Chicken Pox Vaccine 1st _____2nd _____
    Hepatitis B Vaccine 1st_____ 2nd _____ 3rd _____
    Hepatitis A Vaccine 1st_____ 2nd_____

Other immunizations _____

Tuberculin Test: Kind _____ Results _____ Date _____

PHYSICIAN'S RECOMMENDATIONS

I recommend medical attention to the following conditions: _____
_____

Student physical fit to participate in physical education? Yes _____ No _____

_____M.D.

(TO BE FILLED OUT ONLY BY A PHYSICIAN)

South Gibson School Corporation

PLEASE SEND TO:
Owensville Community School
Pam Grubb, RN
6569 S SR 65
Owensville, IN 47665

Name _____

Teeth _____

Gums _____

Number filled _____

Number cavities _____

Recommendations _____

_____

_____

_____

_____

(Date of examination)

_____

(Dentist's signature)

South Gibson School Corporation

PLEASE SEND TO:
Owensville Community School
Pam Grubb, RN
6569 S SR 65
Owensville, IN 47665

PAST MEDICAL HISTORY

NAME _____ DATE _____

ADDRESS _____ TELEPHONE _____

DATE OF BIRTH _____ SEX _____

Number of children in family _____ Name of family doctor _____

1. Diseases (Give approximate Year)
   Whooping Cough _____ Rheumatic Fever _____ Eczema _____
   Chickenpox _____ Poliomyelitis _____ Nose Bleeds _____
   Measles (regular) _____ Bronchitis _____ Asthma _____
   Measles (3-day) _____ Pneumonia _____ Allergies (specify) _____
   Mumps _____ Epilepsy _____ _____
   Scarlet Fever _____ Hepatitis _____

*** Need to know year of chickenpox disease or if you haven't had chickenpox need to get vaccine.**

2. Operations (Give dates) _____
3. Accidents (Give dates) _____
4. Was this a normal birth? _____
5. Earliest age of: Age of Sitting _____ Age of First Tooth _____
   Age of Walking _____ Age of First Words _____
   Age of Sentences _____
6. Speech Difficulties _____
7. Earache _____ Discharging ear _____
8. Convulsions (Give dates) _____
9. Is your child taking medicine regularly? _____ If so, what? _____

_____

_____

10. Nervous Habits: _____ Bed Wetting _____
    Temper Tantrums _____ Nail Biting _____
    Thumb Sucking _____ Cries Easily _____
11. Tuberculosis Contacts (state who and when) _____
12. Is there any diabetes in family? _____
13. Additional health information _____

_____

_____

_____

_____
Parent Signature

NOTE: Please use back of this form for additional notations.