Hope Preschool
Physical Examination Form

Child's Name_____
Birthdate:_____Sex:_____SSN:_____
Address:_____
City:_____ State:_____ Zip:_____

Health History

To be completed by parent of guardian:

Chicken Pox	YES	NO	Vision Problems	YES	NO
TB/TB Contact	YES	NO	Serious Injuries	YES	NO
Birth Defects	YES	NO	Bone Joint Problems	YES	NO
Blood Disorder	YES	NO	Surgery	YES	NO
Hemophilia____ sickle cell____			Hospitalization	YES	NO
Diabetes	YES	NO	Asthma	YES	NO
Seizures	YES	NO	Medications_____		
Heart Problems	YES	NO	_____		
Ear/Hearing Problems	YES	NO	_____		
Chronic Ear Infections	YES	NO	Explanation to any of the above____		
Speech Problems	YES	NO	_____		
			_____		

Parent's or Guardian's Signature_____Date_____

To be completed by Physician:

Age_____ Height_____ Weight_____

Normal

- ❑ Skin_____
- ❑ Eyes_____
- ❑ Lymph Nodes_____
- ❑ Mouth_____
- ❑ Gingiva_____
- ❑ Throat_____
- ❑ Heart_____
- ❑ Genitalia_____
- ❑ Spine & Back_____
- ❑ Neuromuscular_____
- ❑ Urinalysis_____

Normal

- ☐ Head & Scalp_____
- ☐ Nose_____
- ☐ Ears_____
- ☐ Teeth_____
- ☐ Palette_____
- ☐ Chest_____
- ☐ Lungs_____
- ☐ Abdomen_____
- ☐ Rectum, Anus_____
- ☐ Extremitites_____
- ☐ Gait_____

Vision: (R) eye_____ (L) eye_____ Both_____
Hearing: Normal_____ Abnormal_____ Not tested_____

If needed: Hemoglobin or Hematocrit_____
Tuberculin Screening_____
Sickel cell Screening_____
Developmental testing_____
Lead Screening_____

Allergies:_____
_____

Summary of findings: I have examined_____
He/She is___ is not____ physically and emotionally able to participate in your program.
Additional
Comments:_____
_____
_____

Date of Physical Examination_____

_____
Signature of Physician or Designee

_____
Date