LAFAYETTE COUNTY SCHOOLS
KINDERGARTEN PHYSICAL EXAMINATION

Name of Pupil _____ School _____ Grade _____

Parent's Name _____ Address _____ Phone _____

Immunization given today: _____

Height: _____ Throat: _____

Weight: _____ Teeth: _____

Hemoglobin: _____ Heart: _____

Hematocrit: _____ Lungs: _____

Blood Pressure: _____ Abdomen: _____

Skin: _____ Genitalia: _____

Eyes: _____ Hernia: _____

Ears: _____ Urinalysis: _____

Nose: _____

Date	Vision	Hearing	Comments
	Rt. 20/ Lt. 20/	Audio: Tymp:	

Please indicate, for purposes of follow-up, need for any specific medical, dental, psychiatric, or surgical care, including immunizations. _____

_____

Should child be seen again at a specific time? _____ If yes, how soon? _____

_____ _____

Signature of Physician Date

Please fill this form our prior to going to your physician's office. Take it with you at the time of your child's physical. Please return this form to your child's teacher the first week of school.

Child's Name _____ Date of Birth _____

Immunization History

Vaccine Type	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DPT/DtaP/Td					
Polio					
M-M-R			***	***	***
Hepatitis B					***
Varicella			***	***	***
Other					

Past Illnesses (please supply dates)

Frequent Colds _____

Frequent Sore Throats _____

Sinusitis _____

Abscessed Ears _____

Ear Aches _____

Bronchitis _____

Asthma _____

Allergies _____

Stomach Upsets _____

Kidney Trouble _____

Heart Trouble _____

Rheumatic Fever _____

Ivy Poisoning _____

Convulsions _____

Tuberculosis _____

Diabetes _____

Other _____

Operations or serious injuries _____

_____

_____

DISEASES (GIVE DATE)

Chicken Pox _____

German Measles (3 day) _____

Measles (Red) _____

Scarlet Fever _____

Whooping Cough (Pertussis) _____

Mumps _____

Other _____