

PRESCHOOL HEALTH ASSESSMENT RECORD

Child's Name _____ Address _____ Birth date _____ M ___ F ___
 (Last) (First) (MI)

Parent(s) or Guardian _____ Home Phone _____
 (Father) (Mother)

Child's Physician _____ Dentist _____ Hospital of Choice _____
 Medicine taken regularly _____ Condition which could affect school work _____

Diseases	Date	Operations/Injuries	Date	Immunizations	1	2	3	4	5	6
Chicken Pox				DPT						
Convulsions				DT						
Hepatitis				Td						
Mononucleosis				OPV						
Pneumonia		Allergies		HbCV (Hib)						
Rheumatic Fever				MMR						
Strep Throat				HBV (Hepatitis B)						
		Birthmarks		Varicella						
				Exemptions						

PHYSICAL EXAMINATION

Date:	Height	Weight	Lab Work		Vision			
General Appearance			Hgb.:		With Glasses		No Glasses	
Posture	Blood Pressure:		Hct.:		Right	Left	Right	Left
Nutrition	TB Test	Date:	Positive	Negative	RBC:			
Skin					Urinalysis			
Feet	Lead Screening	Date:	Result:					
Nose and Throat								
Eyes and Ears	COMMENTS by Physician: _____ <i>Signature of Examining Physician:</i>							
Tonsils and Glands								
Hearts and Glands								
Abdomen								
Congenital Anomalies								