HOWARD-WINNESHIEK COMMUNITY SCHOOLS

(PLEASE PRINT) **KINDERGARTEN/PRESCHOOL PHYSICAL FORM**

Last Name, First:_____ Middle Initial: _____ Birthdate: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Family Physician: _____

Medical Clinic: _____ Clinic Phone: _____

Gender: _____ Medication taken regularly: _____

Please circile Yes or No if your child has had the following conditions:

1. Allergies	Yes	No	to Medication/food/latex: _____
2. Asthma	Yes	No	Medications: _____
3. Diabetes	Yes	No	Medications (please submit action plan from MD): _____
4. Eczema	Yes	No	Treatment: _____
5. Ear infections/Tubes	Yes	No	Date/tubes in place? R or L or both: _____
7. Head Injury	Yes	No	Date/Ongoing precautions: _____
8. Seizures	Yes	No	Medications/Triggers: _____
9. Development disorder	Yes	No	_____

10: Other chronic conditions: _____

Parent Signature: _____ Conditions affecting school activites:_____

*****Parents: Please complete the above area before taking to the doctor's office*****

Completed by Physician:

Height (inches):_____ Weight(lbs):_____ Lead Level: _____ Date: _____ (Does not need to be current)

General Appearance: ____Healthy ____Poor Posture:_____

Nutrition: ____Good ____Fair ____Poor Nose /Throat: ____Normal ____Other (see below)

Eyes and Ears: ____Normal ____Other (see below) Tonsils / Glands ____Normal ____Other (see below)

Heart and Lungs: ____Normal ____Other (see below) Abdomen: ____Normal ____Other (see below)

Vision: R eye_____ L eye_____ Dentition: ____No problem ____Needs care ____Needs urgent care

Pertinent Family History: _____

Chronic Diseases:_____

Operations or Injuries:_____

Other (from above):_____

Examined by: _____ Printed Name:_____ Date:_____

(signature)

updated Oct 2020