Preschool Physical Exam

Child's Name: _____ Age Y: ___ M: ___ Date of Birth: ____/____/____

Required: Please complete all blanks	Exam Date: ____/____/____ Blood Pressure _____ Height _____ Weight _____ Vision: Acuity; R/L _____ Abnormality _____ Hearing: _____	Hemoglobin/Hematocrit _____ Date: ____/____/_____ (REQUIRED for ALL Children **over 12 months**. If none on record, please DRAW). Lead Screening Level _____ Date: ____/____/_____ (REQUIRED for ALL Children **over 24 months**. If none on record, please DRAW).

REQUIRED for children who have lived or visited outside the U.S. TB: _____

Please examine:	Normal	Abnormal	Not Examined	Describe abnormal findings
General Appearance/Posture				
Gait/Muscular Coordination				
Social/Communication				
Skin/Head/Scalp				
Vision/Eyes				
Ears, Nose, Throat				
Dental/Oral				
Heart/Lungs				
Abdomen (include hernias)				
Genitalia				
Bones, Joints, Muscles				
Neurological Examination				
Behavior/Interaction				

SUMMARY OF FINDINGS, TREATMENTS, AND RECOMMENDATIONS:

_____

_____

Activity level recommended: _____ Allergies: _____

Routine Medication(s): _____

Clinic Name _____ Phone: ____-____-____ Fax: ____-____-_____

Name of physician (PRINT) _____

Signature of Physician _____ **Date** _____

I am the parent/guardian of the child listed above. I give permission to share this information with MATURA Head Start and/or associated school.

_____ _____ _____

Parent/Guardian Printed Name **Parent/Guardian** Legal Signature **Date** (Valid for two years)