Persevere * Innovate * Serve
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Principal Laura Corcoran

EARLY CHILDHOOD EDUCATION PHYSICAL FORM

This is to certify that I have examined:

Name: _____ Birthdate: _____

Height: _____ Weight: _____ Birthplace: _____

PHYSICAL EXAM: General Development: _____
Nutrition: _____
Head: _____ Chest: _____
Eyes: _____ Heart: _____
Ears: _____ Lungs: _____
Nose: _____ Abdomen: _____
Throat: _____ Extremities: _____
Mouth: _____ Skin: _____
Neck: _____ Back: _____
Reflexes: _____

LAB FINDINGS: Hgb or HCT _____ Urine Dipstick (optional) _____
Lead Screen _____ TB screen (as directed) _____

TREATMENTS, REFERRALS and/or ONGOING MEDICAL CONDITIONS

_____

_____

IMMUNIZATIONS:

DTP	1. _____	2. _____	3. _____	4. _____	5. _____				
OPV	1. _____	2. _____	3. _____	4. _____					
Hib	1. _____	2. _____	3. _____	4. _____					
Hep B	1. _____	2. _____	3. _____						
MMR	1. _____	2. _____	Varicella	1. _____	2. _____				

Is the child up to date on immunizations at this time? Yes _____ No _____
If the answer to the above question is "No", what is needed?

_____

_____

This is to certify that I have examined the above named child on (Date of Exam) _____ and have found the he/she is free from apparent communicable disease and is in suitable condition to attend a preschool program (Early Childhood Program), based on his/her medical history and physical condition.

Physician's Signature _____

Physician's Name (please print) _____

Physician Address/Phone: _____