Arkansas School for the Deaf

Pre-K/Kindergarten Physical Form

To be completed by Physician or qualified Health Professional

Student's Name_____ Health Agency Name_____

Address_____

DOB_____ Phone Number_____

REQUIRED:				ALLERGIES:			
PHYSICAL EXAM / HISTORY	WNL	ABNL	Comments				
SKIN:				MEDICATIONS:			
EYES:							
EARS:							
NOSE:							
MOUTH:				DIET RESTRICTIONS:			
NECK:							
NODES:							
HEART:							
LUNGS:				SPECIAL EQUIPMENT:			
ABDOMEN:							
ENDOCRINE:							
GENITO-URINARY:				Other Comments / Recommendations:			
MUSCULOSKELETAL:							
NEUROLOGICAL:							
DEVELOPMENTAL:							
Gross Motor							
Fine Motor							
Social							
Speech / Language				SUPPLEMENTAL (Optional)			
BP: HR:				LAB	DATE	RESULTS	WNL (CHECK)
HT: WT:				HGB			
IMMUNIZATIONS UTD? (Circle) YES / NO			COMMENTS:	HCT			
HX of CHICKEN POX DZ (Circle) YES/ NO			DATE of DZ: #Doses VARICELLA VACCINE:	OTHER:			

SIGNATURE/TITLE OF HEALTH PROFESSIONAL_____DATE_____