

Cabot Public Schools

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			
				HCT			
IMMUNIZATIONS UTD? (Circle) YES / NO	COMMENTS:			OTHER:			
HX of CHICKEN POX DZ (Circle) YES/ NO	DATE of DZ:	#Doses VARICELLA VACCINE:					

SIGNATURE/TITLE OF HEALTH PROFESSIONAL _____ DATE _____