# 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 |
| 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_____