



Federated Preschool & Mom's Time Out Physical Examination / Immunization Record Forms

Parent or Guardian should complete this page. Physician should complete next page.

Child's Name: _____

Age: _____ Sex: _____

Child's Physician: _____ Phone: _____

Illnesses: _____ Measles _____ Mumps _____ Chicken Pox
 _____ Diphtheria _____ Scarlet Fever Others: _____

Is child subject to: _____ cold? _____ earache? _____ sore throat?

Has child had tonsils and adenoids removed? _____

Does child have any allergies? Please list:

Does child suffer from any chronic illness? Describe:

Does child have any disability? Specify:

Operations or injuries?

Any unusual habits or problems?

Date of most recent dental exam: _____

Immunizations

	1	2	3	4	5
DPT					
OPV					
HIB					
MMR					
Hep B					
TB skin test					

Physical Exam

Height: _____ Weight: _____
 Scalp: _____ Abdomen: _____
 Nose: _____ Back: _____
 Mouth: _____ Posture: _____
 Teeth: _____ Enuresis: _____
 Throat: _____ GI System: _____
 Tonsils: _____ Extremities: _____
 Ears: _____ Nervous System: _____
 Lungs: _____ Heart: _____
 General Rating: _____
 Recommendations: _____
 Physician's Signature: _____ Date: _____