



Federated Preschool Physical Examination/ Immunization Record Forms

Parent or Guardian should complete front. Physician should complete back

Child's Name: _____

Age: _____ Sex: _____

Child's Physician: _____ Phone: _____

Illnesses:

_____ Measles _____ Mumps _____ Chicken Pox, _____
_____ Diphtheria _____ Scarlet Fever Other _____

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?

Where Individual Belief & Vibrant Faith Community Meet



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: _____	G.U. System,; _____
Tonsils: _____	Extremities: _____
Ears: _____	Nervous System _____
Lungs: _____	Heart: _____

Where Individual Belief & Vibrant Faith Community Meet



General Rating: _____

Recommendations: _____

Physician's Signature: _____ Date: _____

Where Individual Belief & Vibrant Faith Community Meet