

**Kindergarten Physical Exam**  
**JASPER SCHOOL DISTRICT**  
 JASPER, ARKANSAS

Child's Name: \_\_\_\_\_

BP: \_\_\_\_/\_\_\_\_

WT: \_\_\_\_\_

HT: \_\_\_\_' \_\_\_\_"

School: \_\_\_\_\_

	NL	ABNL	COMMENTS:
SKIN: color, rash, swelling, hair nails			
EYES: conjunctive, cornea, pupils, extracular movement			
EARS: pirnae, canals, tyromanic membrane appearances			
NOSE: nares, turbinates			
MOUTH: tongue, teeth, oral mucossa, tonsils, pharynx			
NECK: thyroid, range of motion			
NODES: cervical, axillary, inquinaal, other			
HEART: rate, rhythm, S1, S2, murmur, femoral pulses			
CHEST: resp. rate, retractions, auscultation			
ABDOMEN: contour, palpation of liver, spleen, kidney, mass, hernia			
GENITA-URINARY: female external; male penis, meatus, testes, hernia			
MUSCULOSKELETAL: range of motion, tenderness, edema, clubbing, spine (curvature)			
DEVELOPMENTAL			
GROSS MOTOR			
FINE MOTOR			
SOCIAL			
SPEECH/LANGUAGE			

	DATE	NL	ABNL RESULTS
HEMOGLOBIN			
HEMATOCRIT			
URINALYSIS			
OTHER:			

MEDICATIONS: \_\_\_\_\_

DIET RESTRICTIONS: \_\_\_\_\_

SPECIAL EQUIPMENT: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

GENERAL COMMENTS OR RECOMMENDATIONS:  
 \_\_\_\_\_  
 \_\_\_\_\_

I have performed a physical assessment on this child on the date indicated, and have arranged for any follow-up that was or is needed.

\_\_\_\_\_  
 Signature of Health Provider

\_\_\_\_\_  
 Date Signed

\_\_\_\_\_  
 Phone #

\_\_\_\_\_  
 Date of Exam

**Please return to school office as soon as this form is completed.**

ARKANSAS DEPARTMENT OF EDUCATION  
KINDERGARTEN HEALTH HISTORY  
DEVELOPED BY A COMMITTEE OF THE ARKANSAS HEALTH CARE ACCESS COUNCIL

NOTE: To be completed by the parent/guardian of the Kindergarten student prior to the physical examination/nursing assessment.  
PLEASE PRINT.

Student Name: \_\_\_\_\_  
First Middle Last  
Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ School: \_\_\_\_\_  
Medicaid Number: \_\_\_\_\_ Medicaid Physician: \_\_\_\_\_  
Parent/Guardian Name (Male): \_\_\_\_\_ Phone: \_\_\_\_\_  
Parent/Guardian Name (Female): \_\_\_\_\_ Phone: \_\_\_\_\_  
Physician Name, Address, & Phone: \_\_\_\_\_  
Dentist Name, Address, & Phone: \_\_\_\_\_  
Other source(s) from which the student receives health care: \_\_\_\_\_  
Name and Address of private health insurance carrier: \_\_\_\_\_

1. Does your child pay attention when being read to? Yes No
2. Can your child play quietly alone for over ½ hour? Yes No
3. Does your child mind adults and follow instructions? Yes No
4. Does your child speak clearly enough for others to understand? Yes No
5. Does your child object to being left with a sitter? Yes No
6. Can your child dress without help? Yes No
7. Does your child have any speech problems (stammering, delayed speech development, etc.)? Yes No
8. Does your child ever wet or soil him/herself during the day? Yes No
9. Do you have any concerns about your child's general health (eating and sleeping habits, bowel or bladder, posture, teeth, skin, weight, etc.)? Yes No
10. Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes, wear glasses or contact lenses)? Yes No
11. Does your child have any ear or hearing problems (frequent earaches, difficulty hearing, draining ear, use a hearing aid, etc.)? Yes No
12. Does your child have any allergies (food, insects, drugs, pollens, etc.)? Yes No
13. Does your child have any specific sickness that might in your opinion affect his school performance or program? Yes No
  - (a) Has your child received any medical evaluation or other evaluation, the findings of which could help school personnel in meeting his/her health or educational needs? Yes No
  - (b) Does this problem require any health care in the school? Yes No
  - (c) Does your child take medication? Yes No
14. Do you have any concerns about your child's developmental behavior or emotional wellbeing of which the school should be aware? Yes No

If you answered yes to questions 7-14, please describe the problem or concern you have on the back of this form.

By signing below, I understand that information provided on this form may be shared with appropriate personnel for health and education purposes.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date