Sacramento City Unified School District - Child Development Department

Fax: Capital City: (916)433-2738 or Hiram Johnson: (916)277-6698

Preschool Physical Examination

Child's Name: _____ **Birth Date:** _____ **Preschool:** _____

Parent's/Guardian's Authorization: I hereby give my consent to Child Development Department representative and my physician to exchange health information concerning my child.

Parent/Guardian Signature: _____ **Date:** _____

Required (Note: Incomplete or blanks in this section will be returned to Physician to complete)

Date: _____ Hemoglobin/Hematocrit: _____ At Risk for Anemia? Yes ☐ No ☐ Receiving Tx? Yes ☐ No ☐

Date: _____ Blood Lead: _____ug/dl At Risk for Lead Poisoning? Yes ☐ No ☐ Receiving F/u? Yes ☐ No ☐

Date: _____ TB Risk Assessment Given by Provider: Yes ☐ No ☐ Child has TB Risk? Yes ☐ No ☐

If Yes, PPD Date Given:_____ Date Read:_____ Results:_____

Required (Starting at Age 3)

Date: _____ Blood Pressure:_____

Date: _____ Hearing: (*25db @1000,2000,&4000*) **R:** ☐ Pass ☐ Fail **L:** ☐ Pass ☐ Fail

Date: _____ Vision: **R:** 20/____ ☐ Pass ☐ Fail **L:** 20/____ ☐ Pass ☐ Fail

Date of Physical Exam:	**HEIGHT:** **IN**	**WEIGHT:** **LBS**

Examination Results	Normal	Abnormal	Describe Findings / Comments
General Appearance			
Head, Ears, Eyes, Nose & Throat			
Teeth / Gums			
Heart / Lung			
Abdomen / Genitourinary			
Extremities / Skeletal			
Posture and Gait			
Neurological (Fine, Gross Motor)			
Speech			
Skin			
Developmental Status			

Visual Acuity Concerns? ☐ No ☐ Yes, If yes, referred? ☐ Yes ☐ No Name of Specialist _____

Hearing Acuity Concerns? ☐ No ☐ Yes, If yes, referred? ☐ Yes ☐ No Name of Specialist _____

Health Concerns / Diagnoses:

Food Allergy: ☐ No ☐ Yes List _____

Lactose Intolerance: ☐ No ☐ Yes List _____

Other Severe Allergy (e.g. Latex, bee sting, scents): List _____

Medications Taken at Home? ☐ No ☐ Yes, List: _____

Medications Required at School? ☐ No ☐ Yes, List: _____

Physical Activity: ☐ No Restrictions ☐ Limited, Explain: _____

Special Education Services? ☐ No ☐ Yes Active IEP? ☐ No ☐ Yes

Dental Referral: ☐ No ☐ Yes; Dental Varnish Given: ☐ No ☐ Yes; NaFl Given: ☐ No ☐ Yes

Nutrition Counseling Given: ☐ No ☐ Yes Nutrition Counseling Referral: ☐ No ☐ Yes

Physician's Name (PRINT) _____ **Physician's Signature** _____

Medical Group Name _____ **Phone: (____)** _____ **Fax: (____)** _____

Street Address _____ **City:** _____ **State:** _____ **Zip:** _____