

**RRMR Community School District
Preschool and Kindergarten Physical Form**

Child's Name: _____ **Birthdate:** _____ **Age Today:** _____

Date of Exam: _____

Height or Length: _____ **Weight:** _____ **Blood Pressure (start at age 3):** _____

Hgb. Or Hct. (start at 1 yr.): _____ **Blood Lead Level (start at 1 yr.):** _____

Sensory Screenings:

Vision:

Right Eye: _____ **Left Eye:** _____

Hearing:

Right Ear: _____ **Left Ear:** _____

Developmental Screenings:

Personal-Social: _____ **Fine Motor-Adaptive:** _____

Language: _____ **Gross Motor:** _____

Developmental Referral Made Today (circle one): Yes No

Exam Results (n=normal limits, otherwise describe):

HEENT: _____ **Oral/Teeth:** _____ **Date of Last Dental Exam:** _____

Dental Referral Made Today (circle one): Yes No

Heart: _____ **Lungs:** _____ **Stomach/Abdomen:** _____

Genitalia: _____ **Extremities, Joints, Muscles, Spine:** _____

Skin, Lymph Nodes: _____ **Neurological:** _____

Immunizations:

Please attach a copy of Iowa Department of Public Health Immunization Certificate

Health Provider Assessment Statement:

_____ *The child may participate in developmentally appropriate child care/preschool/kindergarten with NO health-related restrictions.*

_____ *The child may participate in developmentally appropriate child care/preschool with these restrictions:*

Doctor Signature: _____

Circle the Provider Credential Type: MD DO PA ARNP

Address: _____ **Phone Number:** _____