Saint Patrick School

PRE-K/KINDERGARTEN PHYSICAL EXAMINATION FORM

STUDENT _____ BIRTHDATE _____ ☐ Male ☐ Female
First Name MI Last Name

FATHER _____ PHONE _____
First Name MI Last Name

MOTHER _____ PHONE _____
First Name MI Last Name

ADDRESS _____
Number & Street PO Box City State Zip

HEIGHT _____ WEIGHT _____ OTHER VS OR LAB _____

GENERAL APPEARANCE _____

SKIN _____ EYES _____ EARS _____

NOSE, MOUTH, THROAT _____ TEETH _____

RESPIRATORY _____ CARDIOVASCULAR _____

GASTROINTESTINAL _____ GENITOURINARY _____

MUSCULAR _____ SKELETAL _____ NEUROLOGICAL _____

Results of vision and hearing screening if done _____

1. Does the child have a health concern which may require EMERGENCY ACTION while he or she is at school? (e.g., seizure disorder, diabetes, heart problem, severe asthma, bleeding problem, bee sting or severe food allergy). NO YES (Circle One) If yes, please describe.

   _____

2. List any allergies and specific reactions: _____
3. Are any allergies LIFE-THREATENING? NO YES (Circle One) If yes, please describe.

   _____

4. Does the student need an EPI Pen?** NO YES (Circle One)
5. Is the student on medication? NO YES (Circle One) If yes, please list medication, dosage and frequency.** _____
6. Are there any restrictions of physical activity or physical education in school? NO YES (Circle One)

   _____

7. Does this student need special nutritional consideration? NO YES (Circle One) If yes, please describe.

   _____

8. Are there any other significant findings on exam, family or health history, or review of systems that may impact this child's health or learning during the school year? _____

   _____

** A prescribed medication order form must be completed for school staff to administer medication at school.

IMMUNIZATIONS GIVEN TODAY _____

SIGNATURE AND TITLE OF HEALTH CARE EXAMINER _____

PRINTED OR TYPED NAME OF EXAMINER _____ DATE OF EXAM _____

ADDRESS AND PHONE OF EXAMINER _____

Saint Patrick School

PRE-K/KINDERGARTEN EYE EXAMINATION FORM

Student's Name _____ Birth Date _____ Sex _____

Parent or Guardian _____ Phone _____

Address _____ County _____

School/Kindergarten _____ City _____

Date Entering Kindergarten _____

The State of Wisconsin encourages parents of Kindergartners to arrange for their child's eyes to be examined by an optometrist or evaluated by a physician by December 31 of the child's first year in school. An examination or evaluation should include, at a minimum, the elements listed below. (By checking the box, the examining doctor is indicating that the element checked was performed.)

- ☐ Brief history (general health and eye health) of the child, including family history
- ☐ General external observation of the child's eyes and surrounding structures
- ☐ Ophthalmoscopic examination through an undilated pupil
- ☐ Gross measurement of peripheral vision
- ☐ Evaluation of eye coordination and function (alignment and motility)
- ☐ Visual acuity for each eye (separately)

Findings:

As a result of this examination, follow-up care for the child is recommended: Yes No

Date of Examination: _____

Doctor/Physician Signature: _____

Print of stamp:

Doctor/Physician Name
Address
Phone

Saint Patrick School

DENTAL EXAM FORM

(To be filled out by your dentist)

Child's Name _____ Date of Birth _____

Address _____

( ) Child is involved in a preventive dental health program.

( ) All necessary dental work has been completed.

( ) Treatment is in progress.

( ) No dental work is necessary.

REMARKS:

_____

_____

DATE _____ SIGNATURE OF DENTIST _____

PRINTED NAME _____