

Physical Form for Preschool Students

Keota Community School District

Date of exam: _____

Student Name: _____ Date of Birth: _____

Height:	Weight:	Blood Pressure:	Lead:	Hgb:	Vision: Lt: Rt:	Hearing:
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Does the exam reveal any abnormality?	Normal	Abnormal	Not Examined	Describe any abnormality
General appearance, posture & gait				
Behavior during exam				
Skin				
Eyes				
Ears				
Nose, mouth, pharynx & tonsils				
Teeth				
Heart				
Lungs				
Abdomen				
Genitalia				
Extremities & feet				
Neurological				
Other				
Disability (diagnosed):			Treatment:	

Summary of findings and recommendations: _____

Signature of Physician or Health Care Provider

Date

Print or stamp Physician name here: