2018-2019 KINDERGARTEN PHYSICAL EXAM & IMMUNIZATIONS RECORD

Wilmington Christian Academy
642 Davids Drive
Wilmington, OH 45177

A physician's report may be used instead of this form.

Name______________________________ Date______________

Address______________________________

City______________________ Zip Code__________

Parent(s)/Guardian______________________________ Phone #______________

Student Birth date______________ Grade______________ Sex__________

Date of Dental Exam______________

Dentist Name______________________

Dentist Address______________________________

KINDERGARTEN – REQUIRED PHYSICAL EXAM (continued on page 2)

Kindergarten Physical Exam Date__________ Physician's or CNP Signature______________________

Physician's Address ______________________________

Allergies______________________________

REQUIRED IMMUNIZATIONS KINDERGARTEN THROUGH 12TH GRADE

Note to parents: Wilmington Christian Academy also requests a copy of the immunization record on either the physician's office form or the county health department form to accompany this health record. Day, month, and year of each dose is required.

DTaP/DTP/DT/Td (1)__________ (2)__________ (3)__________ (4)__________ (5)*__________
(Diphtheria, Tetanus, Pertussis)

POLIO (1)__________ (2)__________ (3)__________ (4)**__________

MMR (1)__________ (2)__________
(Measles, Mumps, Rubella)

HEP B (1)__________ (2)__________ (3)__________
(Hepatitis B)

Varicella
(Chicken pox) (1)__________

Other: ______________________________

*Students receiving all four primary immunization doses of DTP or DTaP prior to their 4th birthday MUST receive a single booster dose prior to kindergarten entry.
**Students receiving a third dose of Polio Vaccine (either DPV or IPV) prior to the 4th birthday MUST receive a fourth dose prior to kindergarten entry.

RECOMMENDED ITEMS FOR SCHOOL PHYSICALS

Did examination reveal any abnormalities in the following areas?

	YES	NO		YES	NO		YES	NO
General Appearance			Neuro Muscular			Skeletal System		
Abdomen			Skin			Lymph Nodes		
Eyes			Ears			Noses/Throat		
Lungs			Genitalia			Teeth/Gums		
Tongue and Palate			Heart BP:			Emotional		

Weight: Height: Head (Inches):

DESCRIBE FULLY ANY ABNORMALITIES:

HCT>34% is acceptable for 3--4 YR	HCT>36% is acceptable for 4--5 YR	HGB> is acceptable for all ages
F.E.P., if HCT or HGB fall below amount indicated.		
Lead Test if R.E.P. is High:	Sickle Cell Anemia:	Urinalysis:
Hearing:	Speech:	Vision:

Injuries and Illnesses -- Please list any severe injuries or illnesses:

Injuries/Illnesses:	Age of Child	Hospitalized: YES	Hospitalized: NO

Indicate your child's past/present disease(s):

____Heart Disease	____Rheumatic Fever	____Diabetes	____Tuberculosis
____Epilepsy, Seizures	____Frequent Skin Infections	____Kidney Disease	____Meningitis
____Chicken Pox	____German Measles	____Sickle Cell Disease	____Mumps
____Eczema	____Old Fashion Measles	____Encephalitis	____Hepatitis B
____AIDS/HIV	____Asthma or Wheezing	____Other	____Stool Soiling

Is your child on any medication? ____Yes ____No Please indicate the medication and reason it is being taken:

Are there medications given "as needed" ___ Yes ____No Please indicate reason medication is being taken:

Does student have a physical handicap? ___Yes ___No
Explain:

Has student ever had a convulsion? ___Yes ___No
Explain:

Describe student's eating habits:

Does student have trouble with bladder control? __Yes __No

Poor Vision? _____Yes _____No

Poor Hearing?_____Yes _____No

Would you say student is ___very active, __average, ___quiet

Nervous twitching or tics? ___Yes ___No

Physical Activity: Limitations? ___Yes ___No
(If child has limitations, please send a note from your physician to the school.)

Is student a bed-wetter? ___Yes ___No

Chronic diarrhea or constipation? ___Yes ___No

Please state any health problems you wish the school to know: