SACRAMENTO CITY UNIFIED SCHOOL DISTRICT - CHILD DEVELOPMENT DEPARTMENT

Hiram Johnson: (916) 395-5500 Fax (916) 277-6698

PRESCHOOL PHYSICAL EXAMINATION

CHILD 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: _____ Receiving Treatment/Iron? Yes ☐ No ☐
Date: _____ Blood Lead: _____ug/dl
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: _____ Vision: **R:** 20/____ ☐ Pass ☐ Fail **L:** 20/____ ☐ Pass ☐ Fail
Date: _____ Hearing: (*25db @1000,2000,&4000*) **R:** ☐ Pass ☐ Fail **L:** ☐ 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			

Health Concerns/Diagnoses:

Food Allergy: ☐ No ☐Yes, List:

Lactose Intolerance: ☐ No ☐Yes ☐Other:

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

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

Physical Activity: ☐ No Restrictions ☐ Limited, Explain:

Special Education Service:
☐ Speech Impairment ☐ Developmental Delay ☐ Learning Disability ☐ Orthopedic Disability
☐ Emotionally Disturbed

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 NAME (PRINT) _____ **PHYSICIAN'S SIGNATURE** _____ **DATE:**_____

MEDICAL GROUP NAME _____ **PHONE: (____)** _____ **FAX: (____)** _____

Street Address_____ **City:** _____ **State:** _____ **Zip:** _____