BISHOP SCHAD REGIONAL SCHOOL
KINDERGARTEN PHYSICAL AND DENTAL EXAMINATION FORMS

Name____ Birth Date ______________
Parent or Guardian_________________________________ Phone _________________
Home Address ____

HEALTH HISTORY (check giving approximate dates)
Fainting _____________ Heart Problems______________ Sinusitis________________
Frequent sore throats_________________ Stomach upsets ________________________
Constipation _____________Convulsions ____________ Ear Infections______________
Kidney disease___________ Rheumatic fever _________ Mumps __________________
Chicken pox _____________ Measles ________________ German Measles__________
Lung infections__________________________TB______________________________
Allergic reactions: Bee sting_______ Drugs __________ Other ____________________
Operations _______________________________ Injuries ________________________
Details or additional information of above _____________________________________

IMMUNIZATIONS (Dates required)
DPT_____________________________ Polio________________________________
MMR____
Measles_____________________ Mumps _______________Rubella________________
HIB____________________________
Hep.B____________________________
TB-PPD____________________ Varicella Vaccine:_______________________

PHYSICAL EXAMINATION:
Height____________ Weight______________BP___________
Eyes_____________ Vision_______________Abdomen__________________________
Glasses_______________________________ Genitalia___________________________
Ears_______________Hearing____________ Extremities_________________________
Nose and Throat_______________________ Posture____________________________
Teeth and Gums________________________
Heart and Lungs________________________
Skin__________________________________
General Appraisal_______________________
____
Recommendations or Restrictions___________
____

Sign: M.D.____________________________

Date of Exam__________________________

DENTAL EXAMINATION
Teeth______________________
No.Carious __________________
Gums: Normal_______________
Inflamed______________
Recommendations:____________
____
____
Sign: D.D.S.
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Date of Exam_________________