

PRE-SCHOOL PHYSICAL EXAMINATION AND IMMUNIZATION RECORD

Name _____ Date of Birth _____

Physical examination record

Height _____

Weight _____

Blood pressure _____

Pulse _____

Vision (r) _____ (l) _____

Hearing (r) _____ (l) _____

Eyes _____

Lungs _____

Ears, Nose, Throat _____

Abdomen _____

Mouth and teeth _____

Skin _____

Neck _____

Genitals/Hernia _____

Heart _____

Extremities _____

Allergies _____

Restrictions from activities _____

Recommendations: _____

Pre-school immunizations * Required# 8 is recommended for pre-school entrance (will be required for **kindergarten**).

Type of Vaccine	Dose 1	Dose 2	Dose 3	Boosters
1 DPT/DTaP	*	*	*	*
2 POLIO	*	*	*	
3 MMR	*			
4 VARICELLA (chicken pox)	* one dose or disease			
5 HIB	*			
6 INFLUENZA (before Dec. 31 st)	*			
7 PNEUMOCOCCAL	*			
8 # Hepatitis B				

Doctor's Name (PRINT) _____

Doctor's Address _____ Telephone _____

Doctor's Signature _____ Date of Exam _____