

# Lafayette County Health Department

729 Clay Street Darlington, Wisconsin 53530  
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## KINDERGARTEN PHYSICAL EXAMINATION

Name of Pupil \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Parent's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Immunization given today: \_\_\_\_\_

Height: \_\_\_\_\_ Throat: \_\_\_\_\_

Weight: \_\_\_\_\_ Teeth: \_\_\_\_\_

Hemoglobin: \_\_\_\_\_ Heart: \_\_\_\_\_

Hematocrit: \_\_\_\_\_ Lungs: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Abdomen: \_\_\_\_\_

Skin: \_\_\_\_\_ Genitalia: \_\_\_\_\_

Eyes: \_\_\_\_\_ Hernia: \_\_\_\_\_

Ears: \_\_\_\_\_ Urinalysis: \_\_\_\_\_

Nose: \_\_\_\_\_

Date	Vision	Hearing	Comments
	Rt. 20/ Lt. 20/	Audio: Tymp:	

Please indicate, for purposes of follow-up, need for any specific medical, dental, psychiatric, or surgical care, including immunizations. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Should child be seen again at a specific time? \_\_\_\_\_ If yes, how soon? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Physician

Date

Please fill this form out prior to going to your physician's office. Take it with you at the time of your child's physical. Please return this form to your child's teacher the first week of school.

Child's Name

Date of Birth

**Immunization History**

Vaccine Type	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DPT/DtaP/Td					
Polio					
M-M-R			***	***	***
Hepatitis B					***
Varicella			***	***	***
Other					

*Past Illnesses (please supply dates)*

Frequent Colds \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Frequent Sore Throats \_\_\_\_\_

Diabetes \_\_\_\_\_

Sinusitis \_\_\_\_\_

Other \_\_\_\_\_

Abscessed Ears \_\_\_\_\_

Operations or serious injuries \_\_\_\_\_

Ear Aches \_\_\_\_\_

\_\_\_\_\_

Bronchitis \_\_\_\_\_

\_\_\_\_\_

Asthma \_\_\_\_\_

DISEASES (GIVE DATE)

Allergies \_\_\_\_\_

Chicken Pox \_\_\_\_\_

Stomach Upsets \_\_\_\_\_

German Measles (3 day) \_\_\_\_\_

Kidney Trouble \_\_\_\_\_

Measles (Red) \_\_\_\_\_

Heart Trouble \_\_\_\_\_

Scarlet Fever \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_

Whooping Cough (Pertussis) \_\_\_\_\_

Ivy Poisoning \_\_\_\_\_

Mumps \_\_\_\_\_

Convulsions \_\_\_\_\_

Other \_\_\_\_\_