

Jasper County Preschool Physical Examination

Child's Name: _____ Date of Physical Examination: _____

Date of Birth: _____

CHDP Periodicity visit for:	1	2	4	6	9	12	15	18	24	30	3	4	5
	Mos	Mos	Mos	Mos	Mos	Mos	Mos	Mos	Mos	Mos	Yrs	Yrs	Yrs

TB Risk Factor Assessment: <input type="checkbox"/> Risk factors not present; TB skin test not required	
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Hematocrit /Hemoglobin 9 Month 2,3,4 Years	Date:	Results:	Anemia: <input type="checkbox"/> Yes <input type="checkbox"/> No	Iron Supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Blood Lead Test: 12 and 24 Month If no record, perform	Date:	Results:	Blood Pressure:	Date:	Results: ____ / ____	
Tuberculin Skin Test	Date Given:	Date Read:	Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Chest X-ray Date:	Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	
Height: (%)	Weight: (%)	BMI:			Head Circumference:	
Vision: Right – 20/____ Left – 20/____			Strabismus: <input type="checkbox"/> Pass <input type="checkbox"/> Fail		Hearing: <input type="checkbox"/> Pass <input type="checkbox"/> Fail	

Examination Results	Normal for age	Abnormal (Describe Findings)	Not Tested	Examination Results	Normal for age	Abnormal (Describe Findings)	Not Tested
Anticipatory Guidance				Eyes/Vision Observation			
Posture, Gait				Ears/Clinic Assessment			
Birth Defects				Developmental Screening			
Ears/Nose/Throat				Autism Spectrum Disorder Screening			
Seizures				Developmental Surveillance			
Mouth/Teeth Dental/Nutrition				Psychosocial/Behavior Assessment			
Heart/Lungs				Communication Skills/Speech			
Asthma				Cognitive Skills			
Abdomen (Hernia)				Maternal Depression Screening			

Is the child cleared to enter preschool? ☐ Yes ☐ No

List any allergies, chronic conditions or special accommodations: _____

List medications required at school (include medication name and dosage): _____

Provider (Please print): _____ Signature: _____

Practice/Clinic Name: _____ Phone Number: _____

Address: _____