

KINDERGARTEN PHYSICAL ASSESSMENT

To be Completed by Physician, Nurse or School Health Professional

REQUIRED				SUPPLEMENTAL (optional)			
	NL	ABNL	Comments	Date	NL	Comments	
B/P: _____ WT: _____ HT: _____							
SKIN: Color, Rash, Swelling, Hair, Nails							
EYES: Conjunctiva, Cornea, Pupils, Extraocular Movement.							
EARS: Pinnae, Canals, Tympanic Membrane, Appearance, Mobility							
NOSE: Nares, Turbinates							
MOUTH: Tongue, Teeth, Oral Mucosa, Tonsils, Pharynx							
NECK: Thyroid, Range of Motion							
NODES: Cervical, Axillary, Inguinal, Other							
HEART: Rate, Rhythm, S1, S2, Murmur, Femoral Pulses							
LUNGS: Rate, Auscultation, Percussion							
ABDOMEN: Contour, Palpation of liver, Spleen, Kidneys, Mass: Tenderness							
GENITO-URINARY: Female external, Male Penis, Meatus, Testes, Hernia							
MUSCULOSKELETAL: Range of Motion, Tenderness, Edema, Clubbing Spine (Curvature).							
NEUROLOGICAL: Gait, Cerebellar Function, Motor System (Strength, Tone): Cranial Nerves (Gross)							
DEVELOPMENTAL							
Gross Motor							
Fine Motor							
Social							
Speech/Language							
				Medications _____ _____ _____ Diet Restrictions _____ _____ _____ Special Equipment _____ _____ _____ Allergies _____ _____ _____ General comments/Recommendations _____ _____ _____ _____ _____ _____			

I have performed a physical assessment on this child on the date indicated, and have arranged for any follow-up that was or is needed.

Signature _____ Phone _____ Date Signed _____ Date of Exam _____
 Physician, Nurse or School Health Professional