Englewood Schools
Belong and Thrive

PHYSICAL EXAM FORM

This form must be completed and returned to the ECE Program prior to enrollment.
Physicals are required on an annual basis in preschool.

Parent: *To be completed by the parent/guardian*

Child's Name: ______________________ Date of Birth: ______________

Allergies: ☐ None ☐ Yes, describe: ______________________

Type of reactions: ______________________

I, ______________________ give consent for my child's health provider and school to discuss my child's health concerns. My child's health provider may fax this form (and applicable attachments) to my child's school. Fax number: **303-806-2535.**

Please FAX form, mail or bring it to: Englewood ECE at Maddox, 700 W. Mansfield Ave. Englewood, CO 80110 Phone: 303-781-7585

______________________ Date: ______________

Parent or Legal Guardian Signature

Health Care Provider: *Please complete after parent section has been completed*

Date of Exam: __________

Date of Next Exam: __________

Required Lab Tests:

Hemoglobin/Hematocrit: ______________ Date of Lab: ______________ -or- ☐ Not at Risk

Blood Lead Level: ______________ Date of Lab: ______________ -or- ☐ Not at Risk

Height: __________ Weight: __________ ☐ Normal for age ☐ Abnormal for age, please note below

Vision: __________ Hearing: __________ Blood Pressure: __________

Tuberculin Test Date: ______________ Results: ______________

Physical Exam: ☐ Normal ☐ Abnormal, please describe: ______________

Significant Health Concerns:

☐ None ☐ Reactive Airways Disease ☐ Seizures ☐ Diabetes ☐ Asthma ☐ Ear Infections

☐ Developmental Delays ☐ Hospitalizations, describe ______________

☐ Other (dental, nutrition, behavior, etc.) please list ______________

Allergies: ☐ None ☐ Moderate Allergies ☐ Severe Allergies, describe reaction and any restrictions:

____

Current Medications/Special Diet: ☐ None ☐ Describe: ______________

Immunizations: ☐ Up-to-date ******(Attach immunization record) ******

☐ Not current ☐ Immunization(s) given today: ______________

Describe any condition requiring special attention by staff or restrictions placed on the child:

____

Physician's Signature:

This child is healthy and may participate in all routine activities in the Early Childhood Program. Any concerns or exceptions are identified on this form.

______________________ __________

Signature of Health Care Provider Date

- Please See Additional Information on Reverse Side -

Office Stamp:

Or write Name, Address, and Phone Number

5/13/2018