

## Rockwood School District Preschool Program PHYSICAL EXAMINATION

The policies set forth in the Rockwood Preschool Program require a physical examination prior to admission. All new students are expected to present evidence of a physical examination. **Please return the completed health examination form to Rockwood's Early Childhood Office at Clarkson Valley, 2730 Valley Rd, Chesterfield MO 63005**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ Zip \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_  
 School \_\_\_\_\_  
 Parent/Guardian \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

HEP A\* \_\_\_\_\_  
 \* not required by MO State Law or Rockwood (info only)

### TO BE COMPLETED BY EXAMINING PHYSICIAN

|                    |               |
|--------------------|---------------|
| Height _____       | Weight _____  |
| Nutrition _____    | Anemia _____  |
| Skin _____         | Scalp _____   |
| Teeth _____        | Gums _____    |
| Nose _____         | Throat _____  |
| Tonsils _____      |               |
| Ears _____         | Eyes _____    |
| Heart _____        | Lungs _____   |
| Abdomen _____      | Hernia _____  |
| Lymph Glands _____ | Urine _____   |
| Diabetes _____     | Posture _____ |

### TO BE COMPLETED BY PARENT - HEALTH HISTORY

Has child ever had any of the following?

Allergies \_\_\_\_\_

Surgeries \_\_\_\_\_

Other Serious Illness \_\_\_\_\_

|                     |                       |
|---------------------|-----------------------|
| Chicken Pox _____   | Diphtheria _____      |
| Measles _____       | German Measles _____  |
| Mumps _____         | Scarlet Fever _____   |
| Diabetes _____      | Rheumatic Fever _____ |
| Poliomyelitis _____ | Pneumonia _____       |
| Tuberculosis _____  | Whooping Cough _____  |
| Others _____        |                       |

Please check any of the following symptoms which have been noted:

|                              |                                       |
|------------------------------|---------------------------------------|
| Convulsive disorder _____    | Frequent pain in legs or joints _____ |
| Frequent colds _____         | Dizziness _____                       |
| Frequent sore throat _____   | Faints easily _____                   |
| Persistent cough _____       | Shortness of breath _____             |
| Frequent draining ears _____ | Tires easily _____                    |
| Hard of hearing _____        | Night sweats _____                    |
| Speech difficulty _____      | Abdominal pain _____                  |
| Husky voice _____            | Hernia (rupture) _____                |
| Frequent styes _____         | Frequent urination _____              |
| Frequent nose bleeds _____   | Others _____                          |

Do immunizations comply with state law? Yes \_\_\_\_\_ No \_\_\_\_\_

Can pupil participate in all facets of the preschool program?

If no, specify: \_\_\_\_\_

Should physical activity at school be restricted? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please state to what extent and for how long: \_\_\_\_\_

Is the child on medication or under medical care at this time?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, specify: \_\_\_\_\_

### IMMUNIZATIONS - Give all Dates (Month/Day/Year)

DPT \_\_\_\_\_

POLIO \_\_\_\_\_

HIB \_\_\_\_\_

Pneumococcal \_\_\_\_\_

MMR \_\_\_\_\_

HEP B \_\_\_\_\_

Varicella (Chicken Pox) \_\_\_\_\_ TINE/PPD\* \_\_\_\_\_

\_\_\_\_\_  
 Signature of Examining Physician

\_\_\_\_\_  
 Date of Examination