Pre K/ KINDERGARTEN PHYSICAL ASSESSMENT

To be completed by Professional Medical Healthcare Provider

REQUIRED

	NL	ABNL	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, Axilary, 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, Cerebullar Function, Motor System (Strength, Tone): Cranial Nerves (Gross)			
DEVELOPMENTAL			
Gross Motor			
Fine Motor			
Social			
Speech/Language			
Hearing Test _____			
Vision Test _____			

SUPPLEMENTAL (optional)

	Date	NL	Comments
Hemoglobin			
Hematocrit			
Urinalysis			
Other			

Medications_____

_____

_____

Diet Restrictions_____

_____

_____

Special Equipment_____

_____

_____

Allergies_____

_____

_____

General comments/Recommendations_____

_____

_____

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_____

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.

Name_____Phone_____ Signed_____Date of Exam_____

Medical Health Care Provider