St. Matthew Preschool Physical

This form should be completed by the physician

____
Child's Legal Name

____
Address

_________________________ ____________________
Date of Birth Sex

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Height__________ Weight_____________

Head Circumference________________cm

Blood Pressure

Urinalysis: Sp. Gravity______Sugar_______
Albumin________ Micro_______

Hemoglobin___________________________

Medications__________________________

Follow-up____________________________

Visual acuity: Rt____ Lt______ Both______

Hearing acuity: Rt___ Lt_____ Both______

X=Normal. Describe impairment

General appearance_______________
Nutrition________________________
Eyes____________________________
Ears____________________________
Nose____________________________
Throat___________________________
Tonsils & Glands_________________
Heart___________________________
Lungs___________________________
Abdomen________________________
Genitalia________________________
Extremities______________________
Neurological findings_____________
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____
Recommendations_________________
____

____
Full Activity______________________
Restrictions______________________

____
Physician's Signature

____
Date