



PULASKI COUNTY SPECIAL SCHOOL DISTRICT

925 East Dixon Road/P.O. Box 8601
 Little Rock, Arkansas 72216
 www.pcssd.org

Pre-k & Kindergarten Physical Exam

Student:	<i>last name</i>	<i>first name</i>	<i>middle Initial</i>	Birthdate:	Day:	Year:
					Month:	
Parent(s):	<i>last name</i>	<i>first name</i>	<i>middle Initial</i>	Gender:	Male	Female

MUST BE COMPLETED BY A PHYSICIAN

Screenings For Entry Into School

Acuity Eye Chart and Tests

Screened with Glasses On: Yes No

	Pass	Fail	Comments
Left Eye			
Right Eye			

Hearing Screening

Screened with Hearing Aid On: Yes No

	Pass	Fail	Comments
Left Ear			
Right Ear			

Weight: _____ lbs

Height: _____ Inches

<u>Chronic Medical Conditions</u> <input type="checkbox"/> NONE Asthma ADD Seizures Diabetes Developmental Disorder Other: _____ Comments: _____	<u>Life-Threatening Allergies</u> <input type="checkbox"/> NONE <input type="checkbox"/> YES: _____ <input type="checkbox"/> Peanut <input type="checkbox"/> ShellFish <input type="checkbox"/> Insect <input type="checkbox"/> Other: _____ <input type="checkbox"/> Epinephrine Dose: _____	<u>Non Life-Threatening Allergy</u> <input type="checkbox"/> NONE <input type="checkbox"/> Milk <input type="checkbox"/> Gluten <input type="checkbox"/> Environmental <input type="checkbox"/> Other: _____
<u>Medications:</u> _____		<u>Medical Treatments or Procedures:</u> _____

REQUIRED PHYSICAL EXAMINATION

Area Of Assessment	Within Normal Limits	Not within Normal Limits	Comments and/or recommendations	Complete	Immunization Requirements	Needs Shot
SKIN					DTap: 4 doses 1 after 4th birthday	
EYES					Pollo: 3 doses 1 after 4 th birthday *Pre-K requires 4	
EARS					MMR: 2 doses *Pre-K requires 1	
NOSE					Hepatitis B: 3 doses	
MOUTH					Hepatitis A: 1 dose *Pre-K requires 2	
NECK					Varicella: 2 doses *Pre-k requires 1	
LYMPH NODES					Pneumococcal: 1 Dose *Pre-k ONLY	
HEART				History of Surgery or Hospitalizations		
LUNGS				General Comments or Recommendations		
ABDOMEN						
GENITO-URNINARY			<input type="checkbox"/> Continent of bowel & bladder			
MUSCULOSKELETAL						
NEUROLOGICAL						
DEVELOPMENTAL						

The information provided is complete and arrangements have been made for any referral or follow up as needed.

Signature of Physician/Health Care Provider: _____

Date: _____