Name: KINDERGARTEN PHYSICAL ASSESSMENT To be Completed by Physician, Nurse or School Health Professional REQUIRED SUPPLEMENTAL (optional) Date NL Comments NL **ABNL** Comments Hemoglobin B/P: Hematocrit WT:____HT:____ Urinalysis SKIN: Color, Rash, Swelling, Hair, Other Nails EYES: Conjunctiva, Cornea, Pupils, Extraocular Movement. EARS: Pinnae, Canais, Tympanic Membrane, Appearance, Mobility Medications NOSE: Nares, Turbinates MOUTH: Tongue, Teeth, Oral Mucosa Tonsils. Pharvnx NECK: Thyroid Range of Motion NODES: Cervical, Axilary, Inguinal, Diet Restrictions 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, Special Equipment_____ 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) Allergies____ DEVELOPMENTAL Gross Motor Fine Motor Social Speech/Language General comments/Recommendations_

Physician, Nurse or School Health Professional