Sanford School Department

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PRE-K AND KINDERGARTEN
PHYSICAL EXAMINATION VERIFICATION

Student's Name: _____ Date of Birth: ____/____/____

To Be Completed By Physician

Height _____	Weight _____ BMI_____	Lungs _____
Heart _____	Blood Pressure _____	Eyes _____
Abdomen _____	Hemoglobin _____	Ears _____
Genitalia _____	Hernia _____	Nose _____
Muscular-skeletal _____	Throat _____	Reflexes _____
Glands _____	Urinalysis _____	Orthopedic _____
Nervous System _____	Feet _____ Skin _____	Scalp _____

Remarks and Recommendations: _____

Immunizations:

* DPT	1. _____	2. _____	3. _____	4. _____	5. _____
*OPV	1. _____	2. _____	3. _____	4. _____	5. _____
*MMR	1. _____	2. _____	3. _____	4. _____	5. _____
*Varicella	1. _____	2. _____	or ❑ Varicella Disease: _____	or Titer: _____	
HIB	1. _____	2. _____	3. _____	4. _____	5. _____
Hep B	1. _____	2. _____	3. _____	4. _____	5. _____

* Denotes immunizations required by law before entry to school.

Lead Screening: _____
TB (tine, PPD): _____ Results: _____
Vision Test: _____
Hearing Test: _____

_____ _____
Physician's Signature Date

_____ _____
Print Name Telephone