# KINDERGARTEN PHYSICAL ASSESSMENT

To be Completed by Physician, Nurse or School Health Professional

## REQUIRED

| | NL | ABNL | Comments |
|---|---|---|---|
| B/P:_____<br>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 | | | |
| | | | |

## 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.

Signature_____Phone_____Date Signed_____Date of Exam_____

Physician, Nurse or School Health Professional