

Lancaster City Schools

Early Childhood Programs – Physical Exam

Child's Name _____ Sex _____ Birthdate _____
 Address _____ Phone _____
 Parent's Name _____
 Physician's Name: *(please print)* _____ **Date of Exam:** _____

****PLEASE COMPLETE BOTH SIDES OF THIS FORM**

Immunizations	Please circle one	
Complete for age	Yes	No
In Process	Yes	No

Please Attach Immunization Record

Exempt from Immunization	Please circle one	
Religious Conviction	Yes	No
Health Concern	Yes	No
Other:		

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program.			Reason not completed (check which applies)	
Assessments/Screenings	Results	Date completed	Health Professional decision	Examples: religious conviction, insurance coverage, other
Height				
Weight				
Lead				
Hemoglobin				

Limitations or health condition (including allergies, medications, dietary restrictions or concerns)

Other recommended screenings:

Vision

Hearing

This child has been examined and is in suitable condition to participate in group care.

Signature of Examining Physician/Physicians Assistant or Advanced Practice Nurse (circle one) Address: Phone:	Date of Exam
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Prenatal History

Did the mother have any unusual physical or emotional illness during this pregnancy? ___ no ___ yes.

If yes, explain briefly _____

How old was mother when child was born? ___ Was infant born full term ___ late ___ early ___

Infant's birth weight: _____

Any sickness or problems in the nursery at the hospital ___ no ___ yes. If yes, please explain _____

Developmental History

Give approximate age at which this child: walked alone _____, toilet trained _____, spoke in sentences _____, dressed self _____. How does this child's development compare to other children, such as his/her brother/sisters or playmates? About same ___ slower ___ faster ____.

Additional Information

What medications, if any, are given daily? _____

What medications are given frequently, but not daily? _____

Child's communication is ___ Verbal ___ Non Verbal

Hearing: ___ Normal ___ Hearing Impaired, (Hearing Aid ___yes ___no)

This child is usually: very active ___ normally active ___ rather inactive ___

Please list any severe injuries or illness: _____

Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? ___no ___yes If yes explain briefly: _____

Completed by: _____ Date: _____