



ST. MARY SCHOOL
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Kindergarten Physical Screening

Name of Child: _____ Gender: M ___ F ___

Birth Date: _____ Age: _____

Parent Name: _____

Address: _____

Objective Data: Height: _____ ()% Weight: _____ ()% BP: _____

Screening Tests:

Vision:

Distance Acuity: Right _____ Left: _____
 Muscle Balance: (Near and Far): Pass _____ Fail _____ Not Done _____
 Farsightedness: Pass _____ Fail _____ Not Done _____
 Color: Pass _____ Fail _____ Not Done _____
 Child wears glasses? Yes _____ No _____
 Tested with glasses? Yes _____ No _____
 Referral made? Yes _____ No _____
 Specify test/equipment _____

Hearing:

Pure tone testing:
 Right ear: Pass _____ Fail _____ Not Done _____
 Left ear: Pass _____ Fail _____ Not Done _____
 Child wears hearing aid? Yes _____ No _____
 Tested with hearing aid? Yes _____ No _____
 Referral made? Yes _____ No _____
 Other test (specify) _____

Speech:

Child has discernable speech problem? Yes _____ No _____
 Child has possible problem with:
 Articulation ____ Rhythm ____ Voice ____ Language ____
 Speech evaluation is recommended? Yes _____ No _____

Laboratory Tests:

Hemoglobin/Hematocrit ____ Urine protein ____ Urine blood ____ Urine glucose ____
 Other _____

Physical Examination:

This child is essentially within normal limits _____
 This child is essentially not within normal limits _____

Explain: _____

Does this child have any physical, developmental or behavioral problems that would require the school to provide special attention, programs, or placement?

Explain: _____

Activities and Limitations:

Can the child participate fully in the following activities:

Classroom and academic activities? Yes _____ No _____

Physical Education activities? Yes _____ No _____

Competitive athletics? Yes _____ No _____

Explain any limitations: _____

Allergies:

Medications: _____

Food: _____

Insect bite: _____

List of Medications (if any): _____

Immunizations:

DPT 1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Polio 1 _____ 2 _____ 3 _____ 4 _____

Hep B 1 _____ 2 _____ 3 _____

MMR 1 _____ 2 _____

HIB 1 _____ 2 _____ 3 _____ 4 _____

VARICELLA 1 _____ 2 _____

Examiner:

Name: (print) _____

Address: _____

Phone: _____

Signature: _____

Date: _____