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**

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: ___________________________