PRE-SCHOOL PHYSICAL EXAMINATION AND IMMUNIZATION RECORD

Name _____ Date of Birth _____

Physical examination record

Height_____ Weight_____

Blood pressure_____ Pulse_____

Vision (r)_____(l)_____ Hearing (r)_____(l)_____

Eyes_____ Lungs_____

Ears, Nose, Throat_____ Abdomen_____

Mouth and teeth_____ Skin_____

Neck_____ Genitals/Hernia_____

Heart_____ Extremities_____

Allergies_____ Restrictions from activities_____

Recommendations:_____

_____

Pre-school immunizations ** Required*

8 is *recommended* for pre-school entrance (will be required for **kindergarten**).

Type of Vaccine	**Dose 1**	**Dose 2**	**Dose 3**	**Boosters**
1 DPT/DTaP	*	*	*	*
2 POLIO	*	*	*	
3 MMR	*			
4 VARICELLA (chicken pox)	* one dose *or* disease			
5 HIB	*			
6 INFLUENZA (before Dec. 31st)	*			
7 PNEUMOCOCCAL 8 # Hepatitis B	*			

*Doctor's Name (PRINT)*_____

*Doctor's Address*_____ *Telephone*_____

*Doctor's Signature*_____ *Date of Exam*_____

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