Trinity Lutheran Preschool

PHYSICAL EXAM FORM

P.O. Box 989 • 208 North Dolores Road
Cortez, Colorado 81321

Child's Name: _____

Date of Birth: _____

Parent's Name: _____

NOTE: Please complete each item. A completed physical exam on this form is required for enrollment and continuing classroom attendance.

BASIC DATA

Ht _____ Wt _____ B/P _____ Pulse _____
Head Circumference _____ (as age appropriate)

Nutritional Assessment Adequate _____ Inadequate _____

Hematocrit _____ or Hemoglobin _____
Actual LAB Value Required
(If done in WIC parent is responsible for obtaining date and results)
TB Test (Optional) _____ Results _____ Date _____

Urinalysis (recommended) By dipstick _____ or lab _____

Vision: Acuity: Left: _____ Right: _____
Strabismus Testing: Normal _____ Refer? _____

Hearing: Normal by audiometer? Yes _____ No _____
Speech: Normal by observation? Yes _____ No _____

SYSTEMS REVIEW

Do the following seem normal?

	Yes	No	Refer?
Head			
Skin			
Eyes			
Ears			
Mouth/Nose/Throat			
Nodes			
Heart			
Lungs			
Abdomen			
Ext. Genitals			
Extremities			
Spine			
Neuro			

Were Immunizations Given Today? Yes _____ No _____ (If yes please attach copies of immunization record)

Any illnesses, chronic or disabling problems? _____

Any known allergies? _____

Any need for medications? _____

Any special diet recommended by provider? _____

Does the child seem free of reportable communicable diseases? _____

Does overall development seem normal for age? _____

Other comments or recommendations:

Name of clinic or physician: _____
(Print)

Signature: _____ Date: _____

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: _____ **Date of birth:** _____

Parent/guardian: _____

Required vaccines

	Immunization date(s) MM/DD/YY						Titer date* MM/DD/YY
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella - date of disease		**Varicella** - positive screen date	

*A positive laboratory titer report must be provided to the school to document immunity.

*The shaded area under "Titer date" indicates that a titer is not acceptable proof of immunity for this vaccine.

Recommended vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							

Health care provider signature or stamp: _____ Date: _____

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____ Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

Last Reviewed: October 2018