JACKSON CITY SCHOOLS
KINDERGARTEN PHYSICAL ASSESSMENT

Date_____ Grade_____

Child's Name_____ D.O.B._____

List ALL allergies_____
(foods, bee stings, environmental, medications, etc.)

Medications_____

H_____W_____T_____P_____R_____ History_____

Head_____ Eyes_____

Ears_____ Nose_____

Mouth_____ Teeth_____

Throat_____ Neck_____

Heart_____ Lungs_____

Abdomen_____ Extremities_____

Skin_____ Spine_____

Neuro_____

Immunization record must be complete and up-to-date in accordance with state law. Fill in below with day/month/year or attach an updated copy.

DPT/DTaP_____ _____ _____ _____ _____ MMR_____ _____
Polio _____ _____ _____ _____ Hep B_____ _____ _____
VAR_____ TB_____ Hib_____ _____ _____ _____ Other_____

Comments/Recommendations_____
_____
_____

_____
Signature of Physician/Examiner