

**WEBSTER CITY SCHOOLS  
PRE-KINDERGARTEN – KINDERGARTEN PHYSICAL FORM**

Student Name \_\_\_\_\_ M \_\_\_ F \_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Family Doctor \_\_\_\_\_

Medications taken regularly \_\_\_\_\_

Conditions that would alter school performance \_\_\_\_\_

PHYSICAL EXAMINATION

Date of Visit \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

General Appearance	
Posture	
Nutrition	
Skin	
Feet	
Nose/Throat	
Eyes/Ears	
Vision	
Tonsils/Glands	
Head/Lungs	
Heart	
Abdomen	
Genitals	
Other	

Urinalysis	
Blood Count	
Immunizations given	

Comments \_\_\_\_\_

PHYSICIANS SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_