Rockwood School District Preschool Program
PHYSICAL EXAMINATION

The policies set forth in the Rockwood Preschool Program require a physical examination prior to admission. All new students are expected to present evidence of a physical examination. **Please return the completed health examination form to Rockwood's Early Childhood Office at Clarkson Valley, 2730 Valley Rd, Chesterfield MO 63005**

Name _____

Address _____

City _____ Zip _____

Date of Birth _____ Sex_____

School_____

Parent/Guardian_____

Home Phone _____ Work Phone _____

TO BE COMPLETED BY PARENT - HEALTH HISTORY

Has child ever had any of the following?

Allergies _____

Surgeries _____

Other Serious Illness _____

Chicken Pox	_____	Diptheria	_____
Measles	_____	German Measles	_____
Mumps	_____	Scarlet Fever	_____
Diabetes	_____	Rheumatic Fever	_____
Poliomyelitis	_____	Pneumonia	_____
Tuberculosis	_____	Whooping Cough	_____

Others _____

Please check any of the following symptoms which have been noted:

Convulsive disorder	_____	Frequent pain in legs or joints	_____
Frequent colds	_____	Dizziness	_____
Frequent sore throat	_____	Faints easily	_____
Persistent cough	_____	Shortness of breath	_____
Frequent draining ears	_____	Tires easily	_____
Hard of hearing	_____	Night sweats	_____
Speech difficulty	_____	Abdominal pain	_____
Husky voice	_____	Hernia (rupture)	_____
Frequent styes	_____	Frequent urination	_____
Frequent nose bleeds	_____	Others _____	

IMMUNIZATIONS - Give all Dates (Month/Day/Year)

DPT	_____	_____	_____	_____
POLIO	_____	_____	_____	_____
HIB	_____	_____	_____	_____
Pneumococcal	_____	_____	_____	_____
MMR	_____	_____		
HEP B	_____	_____	_____	

Varicella (Chicken Pox) _____ TINE/PPD* _____

HEP A* _____ _____
* not required by MO State Law or Rockwood (info only)

TO BE COMPLETED BY EXAMINING PHYSICIAN

Height	_____	Weight	_____
Nutrition	_____	Anemia	_____
Skin	_____	Scalp	_____
Teeth	_____	Gums	_____
Nose	_____	Throat	_____
Tonsils	_____		
Ears	_____	Eyes	_____
Heart	_____	Lungs	_____
Abdomen	_____	Hernia	_____
Lymph Glands	_____	Urine	_____
Diabetes	_____	Posture	_____

Do immunizations comply with state law? Yes _____ No _____

Can pupil participate in all facets of the preschool program?

If no, specifiy: _____

_____

_____

_____

Should physical activity at school be restricted? Yes ____ No ____

If yes, please state to what extent and for how long: _____

_____

_____

_____

Is the child on medication or under medical care at this time?

Yes _____ No ____

If yes, specify: _____

_____

_____

_____

_____
Signature of Examining Physician

_____
Date of Examination