ST. FRANCIS CATHEDRAL SCHOOL

Pre-Kindergarten Nurse's Packet

Physician's Report of Physical Examination

Name_____ Birthdate _____ Grade _____

Height_____ Weight_____ Pulse_____ Resp. _____ BP_____

****REQUIRED**

Medical History (eg. Asthma, Seizures, freq OM, etc.) _____

_____

_____

Surgical History_____

_____

Trauma or Injuries_____

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General Appearance_____ Skin_____

Head and Neck_____ Lungs_____

Heart_____

Abdomen_____ Genitalia_____

Musculoskeletal_____

Extremities_____

Other_____

Impressions_____

Immunizations given on this date_____

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Physician's Name, Address, Phone (please Print)

_____ _____

Physician's Signature

_____

_____

Date of Examination