SANTA ANA UNIFIED SCHOOL DISTRICT
EARLY CHILDHOOD EDUCATION PROGRAM
Physical Exam

CENTER _____ TEACHER _____ AM PM FD
CHILD _____ ADDRESS _____
D.O.B. _____ PHONE _____
CHDP Exam YES NO MEDICAL PLAN NAME _____

VISION RESULTS

PASSED R20/ _____ L20/ _____
FAILED R20/ _____ L20/ _____
UNABLE TO CONDITION
REFFERRED TO _____

AUDIOMETRY RESULTS

PASSED R _____ L _____
FAILED R _____ L _____
UNABLE TO CONDITION
REFFERRED TO _____

REQUIRED TB ASSESSMENT

(MUST BE WITHIN 12 MO OF STARTING SCHOOL)
_____ **NO RISK FACTORS OR**
PPD DATE GIVEN _____
PPD DATE READ _____
MM INDURATIONS _____
QUANTIFERON TB
Test Date _____
Result _____

GENERAL HEALTH

LENGTH/HEIGHT _____ WEIGHT _____
BLOOD PRESSURE _____
LEAD SCREEN _____
URINE DIP/URINALYSIS _____

CALIFORNIA STATE REQUIRED IMMUNIZAIONS

	Polio	Dtap	MMR	Hib	Hep B	Pneu
1	/ /	/ /	/ /	/ /	/ /	/ /
2	/ /	/ /	/ /	/ /	/ /	/ /
3	/ /	/ /	**Varicella**	/ /	/ /	
4	/ /	/ /	/ /	/ /	**Hep A**	
5	/ /	/ /	/ /		/ /	
					/ /	

PHYSICAL EXAMINATION

	NORM	ABNORM		NORM	ABNORM		NORM	ABNORM
GEN. APPEARANCE			GLANDS			MUSCULAR COORDIN.		
POSTURE/GAIT			HEART			MOTOR ABILITY		
SPEECH			LUNGS			SELF/HELP SOCIAL SKILLS		
HEAD/NECK			ABDOMEN			COMMUNICATION SKILLS		
EYES			GENITALIA			COGNITIVE SKILLS		
EARS			BONES/JOINTS/MUSCLE			FLUORIDE PRESCRIBED	YES	NO
NOSE			SKIN			OTHER		
MOUTH/TEETH			BACK					

PLEASE EXPLAIN ANY ABNORMAL FINDINGS/ GENERAL STATEMENT ABOUT CHILD'S HEALTH

ASTHMA/ALLERGY Yes No Requires Medication at School Yes No Epi-Pen Inhaler Other _____
If medication is required at school, please complete the medication at school form.
REFERRED TO _____ FOR _____

PHYSICIAN INFORMATION

DOCTOR'S NAME _____
PRINT SIGNATURE **DATE**
DOCTORS ADDRESS _____ PHONE _____

Revised 1/27/20