

# The Columbus Academy

## Pre-Kindergarten Physical Exam

Child's Name \_\_\_\_\_ Date \_\_\_\_\_  
Birth Date \_\_\_\_\_ Sex : \_\_\_\_ male \_\_\_\_ female  
Name of Parent/Guardian \_\_\_\_\_  
Name of Parent/Guardian \_\_\_\_\_

**Immunization Record**-please list the month/day/year or attach separate sheet

DPT \_\_\_\_\_  
Polio \_\_\_\_\_  
MMR \_\_\_\_\_  
Hib \_\_\_\_\_  
HEP B \_\_\_\_\_  
Varivax \_\_\_\_\_

**Physical Exam** (to be completed by child's physician)

HT \_\_\_\_\_ WT \_\_\_\_\_

Please list any abnormal findings: \_\_\_\_\_

Is there any reason this student cannot participate in a full program of school activities?

Yes or No If yes, please explain. \_\_\_\_\_

The above child has been examined and has been found to be free of infections or contagious disease.

Physician's Name (please print) \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date of exam \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

**(students in pre-kindergarten must have physical exam documented every 12 months)**

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

\_\_\_\_\_  
Date

Please return completed form to:

Beckie Hoagland RN, School Nurse

Columbus Academy

4300 Cherry Bottom Rd

Gahanna OH 43230