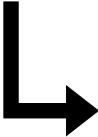


Mack and Poole Pediatrics
Physical Form

Physical Form
(Sample A)



Patient Name: _____ Date of Birth: 11/24/14

Medical History:

Medication Allergies: NKOA Current Medications: none

Significant Medical History: none

Exam Date: 5/24/16

Physical :
General Appearance
HEENT
Skin
Neck
Chest
Heart
Abd-Genitalia
Extremities-Back
Neuro

Normal Exam:

Hgt: 32 1/2 Wgt: 25.9 BP: 1

Immunizations UTD: yes
Date of last Tetanus: 5/24/16

Recommendations:
 No Restrictions: Normal Exam
 Restrictions: See Below

Explain Abnormal Exam: _____

Physician's Signature: M Poole MD Date: 8/10/16

Physical Form
(Sample B)



Mack and Poole
2351 Huguenard Drive, Suite 200
Lexington, KY 40503
859-260-7700

KDE/DDS

KDESHS002

PREVENTATIVE HEALTH CARE EXAMINATION FORM

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school and within one (1) year prior to entry to sixth grade. Local school boards may extend this time not to exceed two (2) months. (102 KAR 1:160)

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____ Gender: M F Grade: _____
Date of Birth: 11/02/2019 Age: 21 mos, 11 days Preferred Language: _____
Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 236.

MEDICAL HISTORY

Allergies: No active medication allergies or reactions; No documented food/non-medication allergies

Current Prescribed Medications to be taken daily at school: _____

Significant Historical Information: _____

SCREENING RESULTS:

Height: 2 ft 11 in Weight: 29 lbs 12 ozs BMI: 0.00 BMI%: 0% BMI²: _____

Visual	Right Eye	Passed	Failed	Referred	Hearing - Right	Passed	Failed	Referred
	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Left Eye	Passed	Failed	Referred	Hearing - Left	Passed	Failed	Referred
	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Options: Hemoglobin: _____ Leads: NORMAL Urinalysis: _____

Gross dental (teeth and gums) Normal Abnormal _____ Refer/Tx _____
 Hand/feet/skin Normal Abnormal _____ Refer/Tx _____
 Eyes/Ears/Nose/Throat Normal Abnormal _____ Refer/Tx _____
 Chest/Lungs/Heart Normal Abnormal _____ Refer/Tx _____
 Abdomen Normal Abnormal _____ Refer/Tx _____
 Scoliosis assessment Normal Abnormal _____ Refer/Tx _____

This child has the following problems that may impact the educational experience:
 Vision Hearing Speech/Language Physical Social/Behavioral Cognitive

Specify: _____

This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below: _____

Recommendations (Attach additional sheet if necessary): _____

(Please Check One)

This child may participate fully in school activities including physical education.
 This child may participate in school activities including physical education with the following restriction/adaptation:
 (Specify reason and restriction) _____

ADAPTATORY GUIDELINES

Discussed and/or handout given

- SCHOOL READINESS
 - Establish routines
 - After-school care/activities
 - Friends
 - Bullying
 - Communicate with teachers
- ORAL HEALTH
 - 60 minutes of exercise/day
 - Regular dental visits
 - Brushing/flossing
 - Fluoride
- MENTAL HEALTH
 - Standby time
 - Anger management
 - Discipline for teaching not punishment
 - Limit TV, computer
- SAFETY
 - Sexual safety
 - Pedestrian safety
 - Safety helmets
 - Swimming safety
 - Fire escape plan
 - Simultaneous monoxide detectors
 - Guns
 - Sun
 - Appropriately restrained in all vehicles
- NUTRITION AND PHYSICAL ACTIVITY
 - Healthy weight
 - Well-balanced diet, including breakfast
 - Fruits, vegetables, whole grains, dairy

Additional comments or recommendations: _____

Signature: _____ Date: 08/13/2021

Physician/AFRN/PA/RN/PT Provider

Address: 1780 Nicholasville Rd, Ste 301, Lexington, KY Telephone: 859-277-8636