

Jac-Cen-Del Kindergarten Physical and Dental Form

This form is to be completed by your doctor and dentist and returned to
Kara Huff, RN. 4544 N. US 421, Osgood, IN 47037 by August 4, 2026.

Student's Name _____ Date of Exam _____

History

Serious Injuries	_____	Surgeries	_____
Severe Illness	_____	Hospitalizations	_____
Seizures	_____	Allergies	_____
Diabetes	_____	Asthma	_____
ADHD	_____	Other	_____

Physical Exam

Height	_____	Weight	_____	Heart:	_____
Eyes:	_____			Posture:	_____
Ears:	_____			Abdomen:	_____
Nose:	_____			Throat:	_____
Lungs:	_____			Other:	_____
	_____				_____

Home Medications: _____ *(If any medications are to be given at school, we must have a doctor's note.)*

Immunizations

Dtap	1	Polio	1	Hep A	1
	2		2		2
	3		3		
	4		4	MMR	1
	5				2
		Hep B	1		
			2	Varicella	1
			3		2

Physician Signature: _____ Phone: _____

DENTAL EXAM:

Date of Exam: _____

Dentist's Comments: _____

Dentist's Signature: _____