To be filled out by doctor and returned to school.

EARLY CHILDHOOD / KINDERGARTEN HEALTH ASSESSMENT

M_____

Child's Name_____ **Addres** _____ **Birthdate**_____ F _____
(Last (First) (Middle)

Parent(s) or Guardian_____ **Home** _____
(Father (Mother

Child's Physician_____ **Dentis** _____ **Hospital of Choice** _____

Medicine taken _____ **Condition which could affect school work**_____

Diseases	Date	Operations/Injuries	Date	Immunizations	1	2	3	4	5	6
Chicken Pox				DPT						
Convulsions				DT						
Hepatitis				T						
Mononucleosis				OPV						
Pneumonia		Allergies		HbCV (Hib)						
Rheumatic Fever				MMR						
Strep Throat				HBV (Hepatitis B)						
		Birthmarks		Varicella						
				Prevnar						
				Exemptions						

PHYSICAL EXAMINATION

Date:	Height	Weight	Lab Work	Vision			
General Appearance			Hgb.:	With Glasses		No Glasses	
Posture	Blood Pressure:		Hct.:	Right	Left	Right	Left
Nutrition	TB Test	Date: Positive Negative	RBC:				
Skin			Urinalysis				
Feet	Lead Screening	Date: Result:					
Nose and Throat							
Eyes and Ears	COMMENTS by Physician:						
Tonsils and Glands							
Heart and Glands							
Abdomen	*Signature of Examining Physician:*						
Congenital Anomalies							

Revised 01/2013