To be filled out by Doctor

PRE-KINDERGARTEN / KINDERGARTEN HEALTH ASSESSMENT RECORD

M_____
F_____

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

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

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

Medication taken regularly_____ **Condition which could affect school work**_____

Diseases	Date	Operations/Injuries	Date	Immunizations	1	2	3	4	5	6
Chicken Pox				DPT						
Convulsions				DT						
Hepatitis				Td						
Mononucleosis				OPV						
Pneumonia		**ALLERGIES**		HbCV (Hib)						
Rheumatic Fever				MMR						
Strep Throat				HBV (Hepatitis B)						
		BIRTHMARKS		Varicella						
				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									
Congenital Anomalies	***Signature of Examining Physician:***								