To be filled out by Doctor *Return at the August Orientation Day*

PRE-KINDERGARTEN / KINDERGARTEN HEALTH ASSESSMENT RECORD

M_____

Child's Name_____ Address_____ Birthdate_____ F _____
(Last) (First) (Middle)

Parent(s) or Guardian_____ Home Phone_____
(Father) (Mother)

Child's Physician_____ Dentist_____ Hospital of Choice_____

Medicine 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							
Hearts and Glands							
Abdomen	*Signature of Examining Physician:*						
Congenital Anomalies							

Revised 01/2008

PLEASE COMPLETE IN FULL AND RETURN ON AUGUST ORIENTATION DAY!

MEDICAL HISTORY

FAMILY INFORMATION

Pupil's Name _____ Birth Date _____ Sex ____
(Last) (First) (Middle)

Address _____ Phone Number _____

Father's Name _____ Occupation _____

Mother's Name (Maiden) _____ Occupation _____

Father's Health _____ If deceased, cause _____ Date _____

Mother's Health _____ If deceased, cause _____ Date _____

Parents in the home: 1 or 2 ____ Married ____ Divorced ____ Separated ____ Single ____

Age of child when single parenting began _____ Child lives with _____

Rank in family: The _____ of _____ children. Number of brothers _____, sisters _____

Medical Insurance:

_____ Blue Cross _____ HMO _____ Heritage _____ Sisco _____ Other/Specify:_____

FAMILY HEALTH HISTORY

Family Physician _____ Phone Number _____

Physician's Address _____

Family Dentist _____ Phone Number _____

Dentist's Address _____

List below anything significant in the family health history (if applicable).

_____

_____

BIRTH AND DEVELOPMENTAL HISTORY

Pupil's birth was:

____ Single	____ Full Term	____ Birth Weight
____ Multiple	____ Instrument	____ Birth Length
____ Caesarian	____ Anesthetic given	____ Apgar Score
____ Premature	____ Condition at Birth	____ Adopted: At Age___

Age of Child When They:

____ Crept	____ Said first word	____ Fed self
____ Began to Walk	____ Spoke first sentence	____ Completed toilet training

What, if any, birth defects has your child had? _____

Does this limit his/her activity in any way? Explain _____

_____

PAST DISEASES — If your child has/had any of the following, state age condition occurred.

____ Mumps	____ Pneumonia	____ Discharging Ears
____ Scarlet Fever	____ High Fever	____ Frequent Ear Aches
____ Rheumatic Fever	____ Convulsions	____ Eye Defects
____ Chicken Pox	____ Heart Disease	

PRESENT HEALTH STATUS — Check any of the following conditions noted recently.

____ Abdominal pains	____ 4 or more colds yearly	____ Hernia
____ Allergy	____ Frequent sore throat	____ Tires Easily
____ Breath Shortness	____ Frequent urination	____ Head Injury
____ Crippling condition	____ Asthma	____ Epilepsy
____ Hay Fever	____ Diabetes	____ Other Conditions

Has your child ever been hospitalized? _____ When/Age? _____

What for? _____ For how long? _____

Has your child ever had any serious accidents, broken bones, or stitches? _____

Explain: _____

_____

Does your child wear glasses? Yes _____ No _____

Does anyone in the family history have vision with color deficiency? _____

Do parents or siblings have high blood pressure? _____

PERSONAL RECORD — Does your child experience any of the following?

____ Seems over active or restless	____ Participates well with other peers	____ Has temper tantrums
____ Has excessive fears	____ Impulsive behavior	____ Eats breakfast

Is your child presently taking medication? _____ Name of Medication _____

Reason for medication _____

Is there any other pertinent information you feel may help us provide better care for your child? If so, please mention below.

_____

_____

_____

_____