To be filled out by Doctor

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						
				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 (Optional) 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 07/2016