

To be filled out by Doctor

# 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 \_\_\_\_\_

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:    Signature of Examining Physician:						
Tonsils and Glands							
Hearts and Glands							
Abdomen							
Congenital Anomalies							