

Dear Parents/Physicians:

Note the vision and hearing screening portion of this form (as well as the immunizations) MUST be completed by the physician before the child enters kindergarten.

Date of Exam _____

Physical Assessment: (please check)

_____ entirely within normal limits

_____ concerns:

Speech Assessment: (please check)

_____ no problems

_____ possible problems (list below)

Is there any reason why the student cannot carry out a full program of school work?

Yes _____

No _____

School Health Examination Record

School _____ Grade _____

Student _____ Birth Date _____

Father or Guardian's Name _____ Place of Employment _____ Business Phone _____

Mother or Guardian's Name _____ Place of Employment _____ Business Phone _____

Describe any health conditions, severe injuries, illnesses, surgical procedures and hospitalizations your child has or had in the past (include allergies and/or reactions to medications, food or any substance and the recommended treatment if the allergy is severe).

List any medications that your child takes daily or frequently.

Please add any comments or concerns you have about your child that you would like the school to be aware of.

Physician's Name _____ Office Phone _____ Signature _____

Immunization

Indicate month/day/year

Type	Date	Date	Date	Date	Date
DTP					
TD					
Polio					
MMR					
Measles					
Rubella					
Mumps					
HBV					
HIB					
Varicella					
Other Identify					

Vision Screening Tests

ALL Screenings required for Kindergarten

	Right	Left
Distance Acuity		
	Distance	Near
Muscle Balance	Pass / Fail	Pass / Fail
Stereopsis	Pass / Fail	Pass / Fail
Color Vision (boys only)	Pass / Fail	Pass / Fail

Hearing Screening Test

Required for Kindergarten

1000 Hz @ 20 db HL	Pass / Fail
2000 Hz @ 20 db HL	Pass / Fail
4000 Hz @ 20 db HL	Pass / Fail

Date of Exam _____

The following services have been performed:

_____ radiographs

_____ oral prophylaxis

_____ flouride treatment

_____ restorations

The following statements are applicable: (please check)

_____ all necessary services have been performed.

_____ further treatment is indicated.

_____ no restorative services are required at this time.

_____ future appointments have been arranged.

Comments:

Signature of Dentist _____