



KINDERGARTEN MEDICAL RECORD FORM

Form must be returned by July 30th to the school office

This section completed by Parent/Guardian:

Child's Name: _____ Female Male Date of Birth: ___/___/___

Address: _____

City: _____ ST: _____ Zip: _____

In case of emergency: Preferred Hospital: _____

Dentist: _____ Phone #: (____) _____

This section completed by Physician and/or other appropriate medical personnel:

Immunizations Dates

DTaP or DPT _____ POLIO _____

MMR _____ HEPB _____ VARICELLA _____

HIB _____ OTHER _____

TB Test: (Required for all students from outside the U.S. within 90 days) Date: _____ Type: _____ Result: _____

Visual Acuity R _____ L _____ Muscle Balance Far _____ Near _____

Hearing Acuity R 1000 Hz at 20 Db _____
 2000 Hz at 20 Db _____
 4000 Hz at 20 Db _____

L 1000 Hz at 20 Db _____
 2000 Hz at 20 Db _____
 4000 Hz at 20 Db _____

Speech Normal Delayed **Communications** Normal Delayed

If delayed, please explain. _____

Do you feel there may be a need for further screening for developmental disorders? No Yes (If yes, please explain)

Allergies: _____

Medication: _____

Medical conditions/diseases: _____

Is child able to participate in all regular physical and athletic activities? Yes No Restrictions: _____

Based upon his/her medical history and physical condition at the time of this examination, this child is free from communicable disease and is in suitable condition for enrollment in school.

Physician's Name: (Please print) _____ **Phone #** (____) _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Physicians Signature: _____ **Date:** _____