KINDERGARTEN HEALTH EXAMINATION FORM

Student's Name _____
(Last) (First) (Middle Initial)

Parent or Guardian's Name _____

Address _____
Telephone Numbers _____

School _____ Grade _____
Birthdate _____ Age _____ Place of Birth _____

Family Physician _____
Significant past illnesses, injuries and surgeries:

_____Allergies	_____Eyes/Ears/Nose/Throat	_____Seizures/Fainting	_____Birth Defects
_____Asthma	_____Head or spinal injuries	_____Skin conditions	_____Fractures
_____Cancer	_____Heart condition	_____Stomach problems	_____Hospitalizations
_____Diabetes	_____Nervous condition	_____Urinary problems	_____Surgeries

Comments: _____
Daily or regular medications: _____

Immunizations	Dates
DPT, DT, DTAP	
OPV, IPV	
Hib	
MMR	
Hep B Series	
Waiver Signed	

I hereby authorize release to the school of the information contained in this document.
Parent _____ **Date** _____

Height _____ Weight _____ Blood Pressure _____
Urinalysis _____ Hgb. Or Hct. _____

	NORMAL	ABNORMAL	COMMENTS
HEAD			
EARS			
EYES			
NOSE			
THROAT			
TEETH			
NECK			
CHEST			
LUNGS			
HEART			
ABDOMEN			
HERNIAS			
GENITALIA			
BACK (SCOLIOSIS)			
EXTREMITIES/FEET			
OTHER			

Student should be excluded from the following activities: _____

Date of Examination _____ Signature of Physician _____