



# KINDERGARTEN MEDICAL RECORD FORM

Form must be returned by July 29th 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 \_\_\_\_\_ L 1000 Hz at 20 Db \_\_\_\_\_  
2000 Hz at 20 Db \_\_\_\_\_ 2000 Hz at 20 Db \_\_\_\_\_  
4000 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:** \_\_\_\_\_