**ALBANY AREA SCHOOLS**

# Kindergarten Health Record

Parent or guardian to complete this section before student is examined by Health Care Provider

Name_____M___F___Date of birth_____
Address_____City_____Phone_____
Parent(s)/Guardian_____
Physician_____Dentist_____

## Significant Health History

Parent or guardian to check conditions that apply & enter approximate date of diagnosis

| | CHECK THOSE THAT APPLY | DATE | | CHECK THOSE THAT APPLY | DATE |
|---|---|---|---|---|---|
| | Allergy, specify food, drug, environmental | | | Diabetes | |
| | Asthma | | | Emotional problem, specify | |
| | Behavioral disorder, specify | | | Orthopedic problem, specify | |
| | Congenital condition, specify | | | Seizure disorder | |
| | Chicken pox | | | Surgery, specify | |
| | Chiropractic care for, specify | | | Other | |

## Health Exam

Physician to complete

| | | | |
|---|---|---|---|
| Height | Eyes | Heart | Allergies |
| Weight | Ears | Neurologic | Nutrition |
| Heart rate | Nose | Bones/Joints | TB test |
| BP | Throat | Scoliosis | Date: |
| U/A | Glands | Skin | Result: |
| Hgb | Lungs | Hernia | |

Significant developmental history _____

Social/emotional problems _____

Hearing _____ Speech _____ Vision _____

List any special health concerns, recommendations or comments _____

_____

List conditions that may limit participation in:

Classroom activity _____
Physical Education _____ Competitive sports _____

Approved for:

___ Full activity ___ Limited activity

_____ _____
Health Care Provider Date

5/07