

**BRIDGEWATER-RARITAN REGIONAL SCHOOL DISTRICT
KINDERGARTEN & PRESCHOOL MEDICAL RECORD**

PAST HEALTH RECORD: To be completed by parent

Date _____
Month _____ Year _____

Child's Name _____
Last _____ First _____ Middle _____

Date and Place of Birth _____ Sex _____

Parents' Names _____
Father _____ Mother _____

Address _____
Street _____ City _____ Zip _____

Phone Number _____

1. Age of Walking _____ 2. Age of Talking _____

3. Behavior (habits): (Write details in blank spaces)

- Speech difficulties _____
- Bed wetting _____
- Disturbed sleep _____
- Nail biting _____
- Finger sucking _____
- Persistent crying _____
- Temper tantrums (type, frequency) _____
- Poor eating habits _____
- Adequate diet _____ Particular dislikes _____
- Bowel habits _____
- Mouth breathing _____

4. Description of General Behavior:

5. Approximate gain in last 12 months: Wt. _____ Ht. _____

6. Diseases (give approximate year):

- | | |
|---------------------------|-------------------------|
| Allergy _____ | Kidney or Bladder _____ |
| Asthma _____ | Problems _____ |
| Bronchitis _____ | Lyme Disease _____ |
| Chicken Pox _____ | Otitis Media _____ |
| Convulsive Disorder _____ | Pneumonia _____ |
| Diabetes _____ | Rheumatic Fever _____ |
| Eczema _____ | Scarlet Fever _____ |

7. Tuberculosis contacts: State who and when (If none, so state)

8. Operations/Injuries _____

9. Eye Symptoms _____ Wears glasses _____

10. Frequent sore throat _____ 11. Frequent earache _____ Hearing problem _____

12. Frequent colds _____ 13. Frequent headache _____ 14. Toothache _____

15. Stomach disorders _____

16. Pain: Joints _____ Muscular _____ Other _____

17. Heart Conditions/murmur _____

18. Hernia _____ Nosebleeds _____

19. Does child take any medication? _____

Has your child been diagnosed with any medical condition? _____ What _____

Parent gives permission for the school nurse to share medical information with school staff as necessary.

Signature of Parent/Guardian

Date

Student's Name _____ D.O.B. _____ Grade: _____ Homeroom: _____

FOLLOWING INFORMATION TO BE COMPLETED BY PHYSICIAN OR MEDICAL PROVIDER

IMMUNIZATIONS: PLEASE ATTACH COPY OF CURRENT IMMUNIZATIONS.

Height: _____ Weight: _____ Blood Pressure: _____ / _____ Pulse: _____ bpm _____

Vision: R 20/ _____ L 20/ _____ Corrected: Yes / No Contacts: Yes / No Glasses: Yes / No

Pupils: Equal _____ Unequal _____ Hearing: R _____ L _____

Indicators	Normal		Abnormal Findings	Initials
Head/Neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Eyes / Sclera /Pupils	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Nose / Mouth / Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Heart: Murmur / Rhythm	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Lungs: Auscultation/Percussion	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Chest Contour	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Skin	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Abdomen: Assessment (include liver, spleen)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Tanner Stage: Testes/Onset of Menses	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Neck/Back/Spine: Range of Motion	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Scoliosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Upper Extremities	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Lower Extremities	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Neurological: Balance & Coordination	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Romberg	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Heel Walk	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Tandem Walk	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Toe Walk	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Nose Touch	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

Allergies:

Additional observations:

CLEARANCE: A. Student may participate in Physical Education: Yes No

B. **NOT CLEARED** for Physical Education:

Diagnosis: _____

Recommendations: _____

Provider's Signature: _____

Date of Exam: _____



Physician/Provider's Stamp