学前班学生健康史
爱荷华市社区学区

致家长:

由您孩子的初级保健医生提供的入学前的健康体检对您孩子的健康和为学校能够根据个人需求来调整其安排都是必要的。根据您孩子的初级保健医生的建议，请您的孩子在入学前进行检查和入学后做定期检查。 请填写表格的这一面。 让您的孩子的初级卫生保健医生填写表的背面。 在学年开始时将填好的表格归还学校。

家长有责任在入学时为每个孩子提供完整的免疫证书!

此页由家长完成:

____________________ ___________________ ______________________________________ _____/_____/____
孩子的姓 孩子的名 地址 出生日期

____ _________________________ _________________________
孩子的医生/护士执业医师/医师助理 电话 首选医院

____ ____________________________
孩子的牙医 电话

你的孩子现有以下的任何一个, 或者他/她曾有以下任何的病史？ 如果答案是肯定的, 请在下面详细说明:

	是	没有	
1.	____	____	哮喘
2.	____	____	癫痫发作
3.	____	____	糖尿病
4.	____	____	心脏问题
5.	____	____	抑郁/焦虑
6.	____	____	注意力缺陷障碍/儿童多动症
7.	____	____	对食物、药物、蜂螯、灰尘/花粉过敏
8.	____	____	头痛
9.	____	____	视觉问题 戴眼镜______ 戴角膜镜_____
10.	____	____	听力问题 左 耳_____ 右 耳_____ 助听器_____
11.	____	____	饮食问题/饮食注意
12.	____	____	肠/膀胱问题

对上面您回答 "是" 的健康状况请详细描述: ____

____

____

KINDERGARTEN STUDENT HEALTH STATUS
IOWA CITY COMMUNITY SCHOOL DISTRICT

NAME ___________________________________ BIRTHDATE_____/_____/_____ DATE OF EXAMINATION___ /_____/_____

THIS SIDE TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, or PHYSICIAN ASSISTANT:
I hereby certify that the above named child was examined by me within the past twelve months and is able to participate in the school program of the Iowa City Community School District. YES [ ] NO [ ]

Height_______________ Weight______________ Blood Pressure_________ Hearing_____________
Vision – ___________ (Please complete Iowa Certificate of Vision Screening)

CONCERNS/ RESTRICTIONS:

1. Does this child have any vision, hearing, or speech concerns that the school should be aware of and/or make accommodations for? YES [ ] NO [ ] Needs further evaluation? YES [ ] NO [ ]	If yes or further evaluation is needed, please describe:
2. Does this child have any condition which may affect the child's participation in: Classroom activities? YES [ ] NO [ ] Physical education/physical activities? YES [ ] NO [ ]	If yes, please describe:
3. Does this child have any condition which may result in a classroom emergency, i.e. asthma, seizures, fainting, diabetes, etc. ? YES [ ] NO [ ]	If yes, please describe:
4. Is there any emotional, mental, or physical condition for which this child should remain under periodic medical observation? YES [ ] NO [ ] Needs further evaluation? YES [ ] NO [ ]	If yes or further evaluation is needed, please describe:
5. Teeth and gums: _____ No obvious problems ______Requires dental care ______Requires urgent dental care	Referral made to:
6. Are immunizations up to date? YES [ ] NO [ ]	If no, please identify missing immunizations and plans for bringing up to date:
7. Has this child received a blood lead screening test, as required by Iowa law? YES [ ] NO [ ]	If so, please give the date and result of the lead screening, and plan for follow up if needed:

_________________________________ _____________ _________________________________ _____________
Physician, NP, or PA Name (Printed) Phone Physician, NP, or PA Signature Today's Date

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