



Los Alamos Public Schools

**Pre-School and Kindergarten
Health Examination by Physician**

School child will attend: : Pre-School Kindergarten

Student

Birth Date Last ____/____/____ First Gender Male Female MI School Year _____

Parent/Guardian:

Home Phone # Last _____ Cell Phone # First _____ Work Phone # Relationship _____

Physician: _____ Fax # _____ Phone # _____

SUMMARY OF PHYSICIANS EXAMINATION

Note to Physician: The information requested below will assist the schools in meeting the child's individual needs.

Vision	Color Vision	Audio
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Please check "Yes" or "No" and specify recommendations:

<input type="checkbox"/> No <input type="checkbox"/> Yes	1. Are there concerns regarding speech/language development?
<input type="checkbox"/> No <input type="checkbox"/> Yes	2. Are there any medical conditions that would limit participation in school activities?
<input type="checkbox"/> No <input type="checkbox"/> Yes	3. Are there conditions which could cause classroom emergencies, (e.g. seizure disorder, diabetes, fainting, allergies, asthma)? Circle those that apply
<input type="checkbox"/> No <input type="checkbox"/> Yes	4. Does this child have any other medical problem with which the school should be concerned?
<input type="checkbox"/> No <input type="checkbox"/> Yes	5. Is the child currently taking any long term medication? If yes, name of medication: _____

Please attach a copy of the immunization record to this form.

Physician's comments: _____

Signature of Physician

Date

Pre-School form: Parents please deliver form to school nurse

Kindergarten form: Los Alamos physicians - Please keep these kindergarten forms until called for by the school nurse

Other physicians - Mail the form to: Los Alamos Public Schools,
Attention Student Services
P.O. Drawer 90
Los Alamos, NM 87544

LAPS Date Received _____