



PRESCHOOL AND KINDERGARTEN PHYSICIAN'S REPORT

Child's Name:	Birthdate:	Sex : ☐ Male ☐ Female
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OBJECTIVE DATA

Height	Weight	BMI (%)	B.P. /
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SCREENING TESTS

VISION	HEARING
Date _____ Distance Acuity right _____ left _____ Muscle Balance ☐ pass ☐ fail ☐ not done Farsightedness ☐ pass ☐ fail ☐ not done Color ☐ pass ☐ fail ☐ not done Child wears glasses? ☐ yes ☐ no Tested with glasses? ☐ yes ☐ no Referral made? ☐ yes ☐ no	Date _____ Pure tone testing: Right ear ☐ pass ☐ fail ☐ not done Left ear ☐ pass ☐ fail ☐ not done Other tests (specify) _____ _____ History of Otitis Media ☐ yes ☐ no Insertion of PE tubes ☐ yes ☐ no Date: _____ Child wears hearing aid? ☐ yes ☐ no Tested with hearing aid? ☐ yes ☐ no Referral made? ☐ yes ☐ no

SPEECH/LANGUAGE

Speech assessment:	☐ Done	☐ Not done	☐ Child has no discernible speech problem
Child has possible problem with:	☐ Articulation	☐ Rhythm	☐ Voice ☐ Language
Speech evaluation recommended:	☐ Yes	☐ No	

IMMUNIZATION RECORD

TYPE	DATE					
DTP/DTaP//DT	/ / *	/ / *	/ / *	/ / *	/ / *	/ / *
Polio	/ / *	/ / *	/ / *	/ / *	/ / *	/ / *
MMR Combined	/ / *	/ / *	/ / *	/ / *	/ / *	/ / *
Measles (Rubeola)	/ /	/ /				
Rubella	/ /	/ /				
Mumps	/ /	/ /				
Hepatitis B	/ / *	/ / *	/ / *			
Varicella	/ /	/ /				
HIB	/ / *	/ / *	/ / *	/ / *	/ / *	/ / *
Tuberculin Test (if new to the country)	Date of Test:		Results of Test:			

* Required compulsory immunization

SUMMARY OF SIGNIFICANT HEALTH HISTORY (Please attach additional pages if needed)

Child's Name:
LABORATORY TESTS
☐ Hematocrit/Hemoglobin ☐ Urine protein ☐ Urine blood ☐ Urine glucose ☐ Lead level ☐ Other:
Atlantoaxial Instability x-ray: ☐ Done ☐ Not done (Down's Syndrome Only) ☐ Positive ☐ Negative Date:
PHYSICAL EXAMINATION:
Date examined: ☐ Essentially normal Abnormalities as follows:
Is this child able to participate fully in the following: A. Classroom and academic activities? ☐ yes ☐ no B. Gross motor activities such as running, tumbling, climbing, etc.? ☐ yes ☐ no If limitations are advised, please specify those limitations:
If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement or attention?

PHYSICIAN'S ASSESSMENT	
Problem list	Recommendation for school management
1.	
2.	
3.	

PLEASE PRINT OR STAMP	
Physician's name	Physician's signature
Address	Date examined
Phone	Date signed

OVER - PLEASE COMPLETE OTHER SIDE