

**College Community Schools
Medical Examination for Kindergarten Students**

Student's Legal Name _____ Prairie Crest _____
 Address _____ Prairie Heights _____
 Date of Birth _____ Sex M F Doctor _____
 Prairie Ridge _____
 Prairie View _____
 Parent or Legal Guardian _____ Doctor's Phone Number _____

Height _____ Weight _____
 Allergies _____
 Blood Pressure _____
 Urinalysis: Sp. Gr. _____ Sugar _____
 Albumin _____ Micro _____
 Hemoglobin _____ Hct _____
 Medication _____
 Visual Acuity: Rt. ___ Lt. ___ Both _____
 Hearing Acuity: Rt. ___ Lt. ___ Both _____

IMMUNIZATIONS			
	Mo.	Day	Yr.
DPT	1		
	2		
	3		
	4		
	5		
Polio	1		
	2		
	3		
	4		
	5		
MMR	1		
	2		
Haemophilus b	1		
	2		
	3		
	4		
Hepatitis B	1		
	2		
	3		
Varivax			

√ = normal. Describe impairment.

General appearance _____
 Nutrition _____
 Eyes _____
 Ears _____
 Nose _____
 Throat _____
 Tonsils & glands _____
 Heart _____
 Lungs _____
 Abdomen _____
 Genitalia _____
 Extremities _____
 Neurological findings _____

 Did you recommend a referral? _____

 Recommendations _____
 Full activity _____
 Restrictions _____

Date of Examination

Signature of Physician

Printed Name of Physician