District #110 Kindergarten Health Assessment

To be completed by a Physician, Physician Assistant or Nurse Practitioner

Student's Name (Last, First, Middle)	Birth Date (Month, Day, Year)	Gender (Male, Female)	Name of School	Grade

Does the child have a diagnosed medical condition? ☐ NO ☐ YES (please explain) :

Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g. seizures, severe allergies, asthma, diabetes etc?)
☐ NO ☐ YES (please explain) :

Physical Findings

Physical Exam	WNL	ABNL	Comments	Physical Exam	WNL	ABNL	Comments
Head	☐	☐		Dental	☐	☐	
Eyes/Vision R_____ L____ Corrective Lenses? No Yes	☐	☐		ENT/Hearing R____ L____ Hx of ear surgery? No Yes	☐	☐	
Respiratory	☐	☐		Orthopedic	☐	☐	
Cardiac	☐	☐		Neurological	☐	☐	
Gastrointestinal	☐	☐		Skin	☐	☐	
Genitourinary	☐	☐		Endocrine	☐	☐	
Musculoskeletal	☐	☐		Surgical History	☐	☐	

Concerns

Other Areas of Concern	NO	YES	Comments	Other Areas of Concern	NO	YES	Comments
Attention Deficit/Hyperactivity	☐	☐		Mobility	☐	☐	
Behavior/Adjustment	☐	☐		Nutrition	☐	☐	
Developmental	☐	☐		Physical Illness/Impairment	☐	☐	
Immunodeficiency	☐	☐		Psychosocial	☐	☐	
Lead Exposure/Elevated Lead	☐	☐		Speech/Language	☐	☐	
Learning Disabilities/Problems	☐	☐		Significant Birth History	☐	☐	

__NOTE__ A medication administration form must be completed for any medication to be administered at school

Is the child on medication? ☐ NO ☐ YES if yes, indicate medication and diagnosis:

Any medication allergies? ☐ NO ☐ YES if yes, list allergies:

Should there be any restriction on physical activity in school? ☐ NO ☐ YES if yes, specify nature of restriction:

RECORD OF IMMUNIZATIONS - MN State Law requires proof of immunizations by a health care provider. Please attach copy of child's current immunization status.
Immunizations given at this visit:

Screenings	Results	Comment
Blood Pressure		
Height / Weight		
BMI Percentile		
Hemoglobin		

(Child's Name) _____ has had a complete physical examination and has:

☐ No evident problem that may affect learning or full school participation.

☐ Problems identified above

Additional comments:

_____ _____ _____

Signature of Health Care Provider | Today's Date | Name of Clinic / Phone Number