ST. MARY SCHOOL

St. Mary School

Physician's Kindergarten Health Assessment

This form must be completed before school begins. If possible, return at Kindergarten Screening.

Student's Name	Sex ___ Male ___ Female	Date of Birth	
Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed ___/___/___

Distance Acuity	__R __L
Muscle Balance	__Pass __Fail
Stereopsis	__Pass __Fail
Color	__Pass __Fail
Child wears glasses?	__Yes __No
Tested with glasses?	__Yes __No
Referral made?	__Yes __No

Hearing

Date performed ___/___/___

Pure Tone	
Right ear	__Pass __Fail
Left ear	__Pass __Fail
Child wears hearing aid?	__Yes __No
Child under the care of a hearing specialist?	__Yes __No
Referral made?	__Yes __No

Postural

Date performed ___/___/___

__No abnormality noted
__Screening not done
__Referral made
Comments:

Speech/Language

Speech assessment completed	__Yes __No
Child has no discernible speech problem	__Yes __No
Speech evaluation recommended	__Yes __No
Child has possible problem with _____	

Lead Poisoning

__Date _____ Type __C __V Results _____µg/dL
__Date _____ Type __C __V Results _____µg/dL

Health History (Serious or chronic illnesses/injuries/surgeries)

Physical Examination Date of most recent examination ___/___/___

__Essentially normal __Abnormalities as follows

Is this child able to participate fully in:

Classroom and academic activities	__Yes __No	Physical education classes	__Yes __No
Competition athletics	__Yes __No	Contact and collision sports	__Yes __No

If limitations are advised, please specify

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

Health Care Provider's signature	Print Name	Phone
Address		Date
City	State	Zip

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Oral Assessment

Student's Name	Date of Birth

The following services have been performed (please check all that apply)

__ Examination	__ Fluoride application	__ Oral prophylaxis (cleaning)	__ Prescription for fluoride supplement
__ Orthodontic assessment	__ Radiography	__ Dental sealant	__ Treatment (restoration, pulp therapy)
__ Other _____			

The following oral hygiene instruction was provided (please check all that apply)

__ Toothbrushing	__ Flossing	__ Dietary counseling	__ Use of fluoride mouthrinse
__ Other _____			

The following statements are applicable (please check all that apply)

__ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
__ No restorative services are required at this time.
__ Further treatment is indicated. (See comments).
__ Routine recall visits recommended.

Comments:

Dentist's signature	Print Name	Phone
Address		Date
City	State	Zip