EAST CLINTON
SCHOOL/KINDERGARTEN HEALTH RECORD

Physician Name, Address, Phone Number
(Printed or Stamped)

Student's Name _____

Date of Birth _____

Date of Examination _____

Grade This Year _____

	WNL	*Recommendations/Referrals*
Head/Circumference		
Eyes		
Ears		
Nose		
Tonsils/Adenoids		
Mouth/Teeth/Gums		
Throat/Thyroid/Glands		
Heart		
Lungs/Chest		
Abdomen		
Hernia		
Genitals		
Neurological		
Skin/Nails/Scalp		
Spine		
Postural Assessment		
Musclo/Skeletal		
Feet		
Overall Age Development		
Appearance		
Nutrition		
Emotional		
Mental		
Behavioral		
Speech		

Height _____

Weight _____

BMI % _____

☐ WNL _____

☐ At risk - underweight

☐ At risk - overweight

☐ Overweight

☐ Obese

B/P _____

HCT _____

Visual Acuity:
Right _____ Left _____

Auditory Acuity:
Right _____
Left _____

☐ Ready for Kindergarten/School Grade _____

☐ No Restrictions on Activities or PE

☐ Restricted on Activities or PE
Specify/Adaptation _____

☐ Recommendations _____

Examiner's Signature _____

Existing Conditions

☐ Asthma
☐ Behavioral/Mental
☐ Diabetes
☐ Seizures
☐ Cystic Fibrosis
☐ Food Allergies

Treatments/Medications
☐ Inhaler
☐ Medications: Please List

Please fill out immunization record below or include/attach office copy.

DISEASE HISTORY	*DATE*	*IMMUNIZATIONS*	*DATE*	*DATE*	*DATE*	*DATE*	*DATE*	*DATE*
Chicken Pox		DTaP						
Mumps		TDaP						
Measles		Polio						
Scarlet Fever		Hepatitis A						
Whooping Cough		Hepatitis B						
		HIB						
		MMR						
		Menactra						
		Varicella						

Immunizations Required for Entry to Kindergarten:

5- DPT
4- Polio
3-Hepatitis B
2- MMR
2-Varicella

☐ Immunizations up-to-date/complete

☐ Immunizations to be scheduled

- ☐ DPT
- ☐ Hepatitis B
- ☐ MMR
- ☐ Polio
- ☐ Varicella