ALBANY AREA SCHOOLS

Kindergarten Health Record

Parent or guardian to complete this section before student is examined by Health Care Provider

Name____________________ M___ F___ Date of birth__________

Address____________________ City_______________ Phone__________

Parent(s)/Guardian____________________

Physician____________________ Dentist____________________

Significant Health History

Parent or guardian to check conditions that apply & enter approximate date of diagnosis

	CHECK THOSE THAT APPLY	DATE		CHECK THOSE THAT APPLY	DATE
	Allergy, specify food, drug, environmental			Diabetes	
	Asthma			Emotional problem, specify	
	Behavioral disorder, specify			Orthopedic problem, specify	
	Congenital condition, specify			Seizure disorder	
	Chicken pox			Surgery, specify	
	Chiropractic care for, specify			Other	

Health Exam

Physician to complete

Height	Eyes	Heart	Allergies
Weight	Ears	Neurologic	Nutrition
Heart rate	Nose	Bones/Joints	TB test
BP	Throat	Scoliosis	Date:
U/A	Glands	Skin	Result:
Hgb	Lungs	Hernia	

Significant developmental history ____________________

Social/emotional problems ____________________

Hearing __________ Speech __________ Vision __________

List any special health concerns, recommendations or comments ____________________

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List conditions that may limit participation in:

Classroom activity __________

Physical Education __________ Competitive sports __________

Approved for:

___ Full activity ___ Limited activity

____

Health Care Provider

____

Date