

**Kaukauna Area School District
Kindergarten Student Health Examination Form**

Student Name _____ D.O.B _____

School _____ Date of Exam _____

Please have the Physician/Nurse Practitioner complete the following:

Height _____ Weight _____ B.M.I. _____ B/P _____

| | Within normal limits | | | Within normal limits | |
|-----------------|----------------------|----|-------------|----------------------|----|
| | Yes | No | | Yes | No |
| Skin | | | Heart | | |
| Eyes | | | Lungs | | |
| Vision | | | Abdomen | | |
| Ears | | | Back | | |
| Hearing | | | Extremities | | |
| Nose and throat | | | Nutrition | | |
| Mouth | | | Optional: | | |
| Dental | | | T.B. screen | | |
| Neck | | | Lead screen | | |

Comments _____

Immunizations up to date yes / no

List immunizations given at this exam _____

Allergies (list specific) _____

If child has allergies, is an Epi-Pen required yes / no

If child has a dairy intolerance, is a hot lunch milk substitute required yes / no

Is child on any routine medication? Yes / no Please explain

Do you wish to see this child again? Yes / no When _____

Are you referring this child to another professional? Yes / no

If so whom? _____

Over

Recommendation for child's school program

Does this child have any specific health needs which should be addressed during the school day?

Yes / no Please explain _____

Does this child have any restrictions for physical education? Yes / no

Please explain _____

Other comments or recommendations _____

Signature of Physician / Nurse Practitioner

Date

Please send completed exam form to:

Mary Sundelius, R.N./School Nurse
Dr. H.B. Tanner Elementary School
2500 Fieldcrest Drive
Kaukauna, WI 54130