SYCAMORE COMMUNITY SCHOOLS
Our students. Our future.

PRESCHOOL AND KINDERGARTEN PHYSICIAN'S REPORT

Only complete if you are registering a preschool or kindergarten student.

Child's Name:	Birthdate:	Sex : [ ] Male [ ] Female

OBJECTIVE DATA

Height	Weight	BMI (%)	B.P. /

SCREENING TESTS

VISION Date

Distance Acuity right _____ left _____

Muscle Balance	☐ pass	☐ fail	☐ not done
Farsightedness	☐ pass	☐ fail	☐ not done
Color	☐ pass	☐ fail	☐ not done
Child wears glasses?	☐ yes	☐ no	
Tested with glasses?	☐ yes	☐ no	
Referral made?	☐ yes	☐ no	

HEARING Date

Pure tone testing:

Right ear	☐ pass	☐ fail	☐ not done
Left ear	☐ pass	☐ fail	☐ not done

Other tests (specify)_____

_____

History of Otitis Media	☐ yes	☐ no	
Insertion of PE tubes	☐ yes	☐ no	Date: _____
Child wears hearing aid?	☐ yes	☐ no	
Tested with hearing aid?	☐ yes	☐ no	
Referral made?	☐ yes	☐ no	

SPEECH/LANGUAGE

Speech assessment:	☐ Done	☐ Not done	☐ Child has no discernible speech problem	
Child has possible problem with:	☐ Articulation	☐ Rhythm	☐ Voice	☐ Language
Speech evaluation recommended:	☐ Yes	☐ No		

IMMUNIZATION RECORD

TYPE	DATE					
DTP/DTaP//DT	/ / *	/ / *	/ / *	/ / *	/ /	/ /
Polio	/ / *	/ / *	/ / *	/ /	/ /	/ /
MMR Combined	/ / *	/ /	/ /	/ /	/ /	/ /
Measles (Rubeola)	/ /	/ /				
Rubella	/ /	/ /				
Mumps	/ /	/ /				
Hepatitis B	/ / *	/ / *	/ / *			
Varicella	/ /	/ /				
HIB	/ / *	/ / *	/ / *	/ / *	/ /	/ /
Tuberculin Test (if new to the country)	Date of Test:		Results of Test:			

* Required compulsory immunization

SUMMARY OF SIGNIFICANT HEALTH HISTORY (Please attach additional pages if needed)

OVER - PLEASE COMPLETE OTHER SIDE

Child's Name:

LABORATORY TESTS

☐ Hematocrit/Hemoglobin ☐ Urine protein ☐ Urine blood ☐ Urine glucose ☐ Lead level ☐ Other:

Atlantoaxial Instability x-ray: ☐ Done ☐ Not done
(Down's Syndrome Only) ☐ Positive ☐ Negative Date:

PHYSICAL EXAMINATION:

Date examined:

☐ Essentially normal Abnormalities as follows:

_____

_____

_____

_____

_____

Is this child able to participate fully in the following:

A. Classroom and academic activities? ☐ yes ☐ no

B. Gross motor activities such as running, tumbling, climbing, etc.? ☐ yes ☐ no

If limitations are advised, please specify those limitations: _____

_____

_____

_____

If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement or attention?

_____

_____

_____

_____

PHYSICIAN'S ASSESSMENT

Problem list	Recommendation for school management
1.	
2.	
3.	

PLEASE PRINT OR STAMP

Physician's name	Physician's signature
Address	Date examined
Phone	Date signed

OVER - PLEASE COMPLETE OTHER SIDE

Rev. 2/14