FREMONT COMMUNITY SCHOOLS-KINDERGARTEN/FIRST GRADE HEALTH REPORT

Must be returned to school on or before the 1st day of school

Name_____ Sex_____ Date of Birth_____

Family Doctor_____

DISEASE AND ILLNESS HISTORY (To be completed by physician)

- Chicken Pox Yes_____ No_____ If yes, date_____
- Allergies_____
- Diabetes_____
- Asthma _____
- Seizures_____
- Other_____

Hospitalizations/Injuries (Type and Date)

_____

Medications_____

PHYSICIAN'S FINDINGS

Height_____ Eyes_____ Mouth_____ Abdomen_____ HB (optional)_____

Weight_____ Throat____ Tonsils_____ Posture_____ Urine_____

Nutrition____ Ears_____ Heart_____ Genitalia_____ Blood Pressure_____

Skin_____ Nose_____ Lungs_____ Other_____

Vision Screen Near *L*_____ *R*_____ Far *L*_____ *R*_____

Recommend professional eye exam Yes_____ No_____
(If yes, Eye Doctor to complete form on reverse side)

Recommendations or Comments

_____

Limitations

_____

Signed_____M.D. Date_____