Shelby City Schools
Physician's Kindergarten Health Assessment

This form must be completed before school begins. If possible, return at Kindergarten Screening.

Student's Name	Sex ____ Male ____ Female	Date of Birth

Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed ___/___/___

Distance Acuity	__ R	__ L
Muscle Balance	__ Pass	__ Fail
Stereopsis	__ Pass	__ Fail
Color	__ Pass	__ Fail
Child wears glasses?	__ Yes	__ No
Tested with glasses?	__ Yes	__ No
Referral made?	__ Yes	__ No

Hearing

Date performed ___/___/___

Pure Tone

Right ear	__ Pass	__ Fail
Left ear	__ Pass	__ Fail
Child wears hearing aid?	__ Yes	__ No
Child under the care of a hearing specialist?	__ Yes	__ No
Referral made?	__ Yes	__ No

Postural

Date performed ___/___/___

__ No abnormality noted
__ Screening not done
__ Referral made
Comments:
_____
_____
_____

Speech/Language

Speech assessment completed	__ Yes	__ No
Child has no discernible speech problem	__ Yes	__ No
Speech evaluation recommended	__ Yes	__ No

Child has possible problem with _____

Lead Poisoning

__ Date _____ Type __ C __ V Results_____µg/dL
__ Date _____ Type __ C __ V Results_____µg/dL

Health History (Serious or chronic illnesses/injuries/surgeries)

_____

Physical Examination Date of most recent examination ___/___/___

__ Essentially normal __ Abnormalities as follows

_____

_____

Is this child able to participate fully in:

Classroom and academic activities	__ Yes __ No	Physical education classes	__ Yes __ No
Competition athletics	__ Yes __ No	Contact and collision sports	__ Yes __ No

If limitations are advised, please specify

_____

_____

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

_____

_____

Health Care Provider's signature	Print Name	Phone
Address		Date
City	State	Zip