



Los Alamos Public Schools
 "We prepare confident, life-long learners."

**Kindergarten Health Examination
 by Physician**

School child will attend: _____

Student _____ School Year _____
 Birth Date ^{Last} ____/____/____ ^{First} _____ ^{MI} _____
 Gender Male Female

Parent/Guardian: _____

 Home Phone # _____ Cell Phone # _____ Work Phone # _____

Physician: _____ Fax # _____ Phone # _____

SUMMARY OF PHYSICIANS EXAMINATION

Note to Physician: The information requested below will assist the schools in meeting the child's individual needs.

Vision	Color Vision	Audio
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Please check "Yes" or "No" and specify recommendations:

<input type="checkbox"/> No <input type="checkbox"/> Yes	1. Are there any delays in speech/language development?
<input type="checkbox"/> No <input type="checkbox"/> Yes	2. Are there any disabilities that would limit participation in school activities?
<input type="checkbox"/> No <input type="checkbox"/> Yes	3. Are there conditions which could cause classroom emergencies, (e.g. seizure disorder, diabetes, fainting, allergies, asthma)? Circle those that apply
<input type="checkbox"/> No <input type="checkbox"/> Yes	4. Does this child have any other medical problem with which the school should be concerned?
<input type="checkbox"/> No <input type="checkbox"/> Yes	5. Is the child currently taking any long term medication? If yes, name of medication: _____

Physician's recommendation to the school: _____

Please attach a copy of the immunization record to this form.

 Signature of Physician

 Date

Los Alamos physicians: Please keep these forms until called for by the school nurse

Other physicians
 Mail the form to:
 Los Alamos Public Schools,
 Attention Student Services
 P.O. Drawer 90
 Los Alamos, NM 87544

 Date Received